

School of Nursing & Midwifery

**Hiding behind a mask: A grounded theory study of
perioperative nurses' experiences of participating in multi-organ
procurement surgery**

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Doctor of Philosophy
of
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DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:

Date:

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“This thesis is dedicated to perioperative nurses and the memories of all organ donors we have been privileged to care for”

ABSTRACT

Multi-organ procurement surgical procedures are undertaken on donors who have consented at the time of their death to donate multiple organs, body parts or tissues. These donors fulfil the criteria for donation by either being certified as brain dead as a result of an injury or via a donation after cardiac death (DCD) pathway. Worldwide multi-organ procurement surgery has made a huge impact in both extending and enhancing the quality of life for recipient patients who have received organs from donors. Perioperative nurses working in surgical teams play a vital role in procuring organs from both paediatric and adult cadaver organ donors. The nature of the surgical procedure used for procuring organs, the urgency of coordinating surgical procurement teams and the removal of organs for urgent transplantation to awaiting recipients is fast paced and technical. The experience has been reported to evoke emotions which traumatically impact on perioperative nurses when assisting in these surgical procedures. There is currently a dearth of research examining the experiences of Australian perioperative nurses assisting within multi-organ procurement surgery.

The objective of this study was to describe and gain a greater understanding of the personal experiences nurses encountered as part of their professional roles when involved in these surgical procedures. This thesis presents the substantive theory which has used a grounded theory methodology to describe the experiences of 35 perioperative nurses working within multi-organ procurement surgical teams from metropolitan, regional and rural hospitals in both New South Wales and Western Australia. The qualitative data from in-depth interviews were simultaneously collected and analysed to develop the substantive theory. The study findings draw attention to the complexities that exist for perioperative nurses to participate in these surgical procedures.

The basic social psychological problem of *hiding behind a mask* was found to be a fundamental shared concern that the majority of perioperative nurses in this study faced when participating in multi-organ procurement surgery. The problem of *hiding behind a mask* was comprised of three stages: *being unprepared*, *being overwhelmed* and *hiding the burden*. The first stage, conceptualised as *being unprepared*, consisted of *not knowing what to expect* during the surgical procedure when they lacked prior knowledge and experience and felt unprepared for *being exposed to death by operating on a cadaver donor* and managing DCD donors within the operating room. Moreover participants were unprepared for *witnessing* the circumstances of each donor patient in addition to *dealing with the grieving family*. During the second stage participants described *being overwhelmed* with *fears of facilitating death* of the donor when they lacked understanding of the process of brain death diagnosis. They reported *being overwhelmed* at also having to witness the *graphic nature of the procurement process* and feeling overwhelmed by their own *emotional responses* to the donor's death which they tried to hide and contain from their work colleagues through *hiding behind a mask*. Lastly the third stage of *hiding behind a mask* was identified as *hiding the burden* where participants were forced to contain their own personal beliefs and attitudes towards these surgical procedures whilst undertaking their professional roles. They reported *hiding behind a mask* when *suppressing personal beliefs*, *hiding an objection to participate*, not disclosing their own views or attitudes on

death and spiritual 'afterlife' beliefs and lastly *hiding not being able to cope* when participating in these surgical procedures. The majority of the participants in this study articulated that various conditions influenced and directly contributed towards their experiences of *hiding behind a mask*. Three conditions were identified and these were reported as: *work conditions, levels of knowledge and experience* and *levels of support*.

In an attempt to overcome the problem of *hiding behind a mask*, the data revealed that participants had to reach a turning point which was labelled as *taking control*. The turning point of *taking control* was described by participants as taking control of their own internal turmoil and rationalising the situation they were placed in whilst also changing their attitudes and thoughts towards their participation in the procedure. Once they had passed through the turning point of *taking control* participants were able to move beyond this point into the basic social psychological process of *finding meaning*.

The basic social psychological process of *finding meaning* comprised of three stages: *pushing through; preserving self* and *coming to terms*. The first stage of *finding meaning* was conceptualised as *pushing through*. For many of the study participants in *pushing through* they dissociated themselves from their internal feelings and conflicts by focusing on the importance of their role and professional contributions towards the surgical procedure. The second stage of the basic social psychological process of *finding meaning* was conceptualised as *preserving self*, this saw participants implement strategies to protect themselves from both the traumatic experiences of procurement surgery and the tragic circumstances of the donors they came in contact with. Three aspects of *preserving self* were identified: *being resilient; nurse self care* and *seeking personal support*. The third and final stage of the basic social psychological process of *finding meaning* was conceptualised as *coming to terms*. During this stage participants were able to gain some understanding from their experiences by *placing their participation role into perspective, honouring the donation wish* and *assisting in preserving life for the greater good* when focusing on the needs of recipient patients requiring the organs they were assisting to procure. Conditions influencing the basic social psychological process of *finding meaning* encompassed: *work conditions, levels of knowledge and experience* and *levels of support*. Participants articulated these as positive influencing conditions such as a changing work environment, feeling less isolated and being supported by their work organisations.

Throughout this thesis pertinent scientific literature has been woven into the research findings to illustrate the relevance of the newly developed theory and to place the substantive theory within the context of other findings and related theories to further support the trustworthiness of the current study data and the newly developed theory. The findings detailed in the substantive theory illustrate new contributions to the knowledge and understanding of the Australian perioperative nurses experiences when undertaking multi-organ procurement surgical procedures which will have relevance both nationally and internationally. The findings have implications and recommendations directed towards perioperative nurses, health services, perioperative organisations, government and policy makers.

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KEY TO TRANSCRIPTS

Throughout this thesis direct quotes have been provided from the participant's interviews. These quotations have been used and woven into the substantive theory. The researcher has used the original wording of each participants quotes however for ease of reading where required the researcher has omitted verbal utterances such as "um" or repeated words. Where relevant the researcher has also inserted a word(s) to provide greater meaning to readers who may not understand lingo used by the perioperative nurse participants. The researcher has also omitted any identifying names of nurses and or organisations to ensure participant's confidentiality is maintained.

The following symbols were used throughout the data in this thesis:

P	Participant
1-35	Numerical code assigned to each participant
<i>Italics</i>	Denote all major conceptual terms carried forward
...	A word or a few words omitted from the quote
....	A sentence or a few sentences omitted from the quote
[]	Information added by the researcher to add clarity
*	Denotes omissions of identifying features such as names of nurses or organisations, health facilities and locations to protect confidentiality

CHAPTER 1

Introduction and Background to the Study

"The necessity to use organs from the dead to save the living must supersede any emotional feelings a surgeon and his or her team may have about the circumstances surrounding individual donors" (Tilney, 2003, p. 162)

1.1 Introduction

This thesis explores the experiences of perioperative nurses participating in multi-organ procurement surgical procedures. Multi-organ procurement surgery is a unique surgical procedure which involves the removal of healthy functioning organs from a deceased donor at the time of their death for the purpose of transplanting them to a single or multiple recipients. In donating their organs, these donors save the lives of many patients suffering from end stage organ failure. It is within this context that this study explores the experiences, role and practices of perioperative nurses who work closest to these procedures within an Australian context. The researcher provides a historical overview of multi-organ procurement surgery and its inception in healthcare both worldwide and within an Australia context. In addition, this chapter details a description of the types of multi-organ donors; brain dead donors and donation after cardiac death donors (DCD), with background information on the changing legislation and development of organ donation and transplantation within Australia. Further, the prevalence of these surgical procedures within an Australian context is also presented. To contextualise the study, relevant literature is provided such as an overview of the multi-organ procurement surgical procedure, the role of the perioperative nurse when participating in multi-organ procurement surgical procedures in addition to relevant issues pertinent to the research study. This chapter concludes with an explanation of the purpose, the primary objectives of the study, and the need for and significance of the study. Further, the chapter concludes with an overview of the organisation of the thesis.

1.2 Multi-organ procurement and transplantation surgery a medical innovation

Worldwide organ transplantation is often the only lifesaving alternative for patients suffering end-stage organ failure. Organ transplantation transforms the lives' of recipients and is considered a miracle of modern medicine (Lock, 2002a). Cadaver donors are utilised as a source of organs for transplantation. Multi-organ procurement surgery from cadaver donors for human transplant was first documented as a medical innovation of the 1960's as a therapeutic alternative for patients in urgent need of healthy organs (Lock, 2002a; Lock, 2002b; Murray, 2001; Starzl, 1992; Tilney, 2003). When alive, these donors consented to donate specified body tissue, organ parts or multiple organs and have since then been classified as brain dead or have suffered cardiac death (Doig & Rocker, 2003; Durall, Laussen & Randolph, 2007; Kolovos, Webster & Bratton, 2007; Levvy, 2006; Price, 2000).

It was during this decade that kidneys, liver, lungs and heart transplants first took place (Lock, 2002a; Starzl, 1992). These earlier procedures were utilised for patients in urgent

need of healthy organs however the procedures were not always successful (Starzl, 1992; Tilney, 2003). The first heart transplant was performed in 1967 by Doctor Christian Barnard in Cape Town, South Africa. The procedure was made possible by the unfortunate death of a donor who had died due to a car accident and had consented to donating her organs. The surgical procurement of the donor's heart was successfully removed and transplanted into the recipient, who survived only 18 days and died after experiencing acute transplant rejection (Lock, 2002a; Lock, 2002b).

Since its inception progress in transplantation surgery techniques and technology has enabled surgeons to successfully transplant a greater number and variety of organs (Starzl, 1992; Tilney, 2003). These advances in technology and techniques have included improvements in organ and tissue compatibility matching, organ preservation methods, surgical techniques, and the use of immunosuppressive agents (Lock, 2002b; Rager, 2004). Further surgical advancements, using cadaveric donors have included the first hand transplant surgery performed in 1998, followed by the first double hand transplant in 2000 (Dubernard, Petruzzo, Lanzetta et al., 2003). Moreover, the first human uterus transplant was undertaken in 2002 (Fageeh, Raffa, Jabbad & Marzouki, 2002). This instigated further research being undertaken into the viability of procuring human uterus's from multi-organ donors during routine procurement surgery (Del Priore, Stega, Sieunarine et al., 2006). Other developments included the first human face allograft transplant which was conducted in 2006 (Devauchelle, Badet, Lengele et al., 2006). Worldwide the surgical procurement of organs from cadavers and transplantation surgery continues to be a widely promoted and accepted medical intervention to treat end stage organ failure or disease which would otherwise lead to the death of the affected person. Organ donation therefore offers recipient patients awaiting organs the opportunity to live longer as well as an improved quality of life (Molzahn, Starzomski & McCormick, 2003; Schnitzler et al., 2005).

1.3 Types of cadaveric multi-organ donors

A person can only be an organ donor at the time of one's death. Therefore the work of transplantation is made possible by the donation of organs from people who agree to provide their organs upon their death. There are two distinct groups of cadaveric donors; brain dead donors and non heart beating donors referred to as Donation after Cardiac Death (DCD) donors (Price, 2000; Standing Committee on Uniform Legislation and Intergovernmental Agreements, 2000; NHMRC, 2009).

1.3.1 The brain dead donor

The term "brain death" was first described in the 1950's and 1960's and referred to patients who had sustained a severe head trauma to the brain. A definition of irreversible coma and criteria for the diagnosis of brain death was first published in 1968, after a decade of research and debate by the Ad Hoc Committee of the Harvard Medical School (Report of the Ad Hoc Committee of the Harvard Medical School, 1968). Neurological trauma can be caused by internal bleeding from a major blow to the head, a vascular disruption such as a stroke, penetrating trauma as is seen from a gunshot wound or from

hypoxic damage associated with drowning or smoke inhalation (Lock, 2002a; Lock, 2002b; Peiffer, 2007). Human consciousness is dependent on the function of the cerebral hemispheres, the higher brain and the reticular activating system in the lower brain stem (Rosenberg, 2009). Therefore permanent unconsciousness occurs when destruction of these structures take place. The National Health & Medical Research Council (2007a) refers to the concept of brain death as:

A widely accepted view emphasises the unity of mind and body in the living human being. From this viewpoint, the death of a person is understood to consist of the irreversible loss of the integrated and coordinated life of the person as a single living organism. When this functional unity is lost irreversibly, the person has died, even if 'life' continues at the sub-personal level of cells, individual organs or isolated physiological systems. A body that lacks all function of the brain lacks this intrinsic unified organisation, even though it may retain some degree of organisation due to the maintenance of some functions by technological means. (p.16)

The diagnosis of brain death by the medical profession is a contentious issue worldwide (Gardiner, Shemie, Manara & Opdam, 2012; Smith, 2012; Truog & Miller, 2008). Endorsing the term brain death as the death of the individual has been accepted by most nations in the world (Gardiner et al., 2012). However, several authors report that some countries either wholly or partially reject it (Lock, 2002b; Price, 2000; Wijdicks, 2002). In Australia, the determination of brain death criteria has been used for many years and is an accepted method of determination of brain death amongst Australian doctors and hospitals (Naffine, Richards & Rogers, 2009). The determination of brain death is certified by two doctors who are not caring for a potential transplant recipient at the time (NHMRC, 2007a). Brain death is established when it is evident that the patient has sustained a brain injury which is severe in nature and accounts for irreversible loss and cessation of brain function (Capron, 2001; Rosenberg, 2009; Truog & Miller, 2008). Clinically, careful examination and testing involves checking that the patient is completely unconscious with a loss of all cranial reflex functions including coughing, gagging, eye movement, blinking and pupillary responses. Further tests include the apnoea test, which is absence of any attempts by the patient to breathe on their own. This is established by disconnecting the patient from the ventilator for a period of several minutes (NHMRC, 2007a). Further the NHMRC (2007a) state:

Death determined by the irreversible loss of all brain function - means that the nature of the brain injury is such that all function of the brain has ceased and the loss of function is permanent. Factors that may temporarily suppress brain function are excluded and the nature of the injury is known and likely to have led to loss of brain function. Clinical tests confirm that the extent of the injury includes loss of brain stem activity. Ancillary tests may be done to confirm absence of blood flow to the brain. (p. 21)

These donor patients remain on ventilators and their organ systems are sustained by artificial nutrition and drugs; the heart continues to beat and their organs (apart from their brain) continue to function until the multi-organ procurement surgery can commence. The nature of their death and the fact that these patients are ventilated allows the opportunity

for donation discussions to take place prior to the organ donation decision. Organs can be recovered anywhere from 24-36 hours after brain death has been declared (NHMRC, 2007a). Families thus can spend time with their loved ones and take the time to come to terms with their loved ones death and the decision made towards the organ donation. Therefore a brain death donation usually affords the donor family the extra time to grieve and say goodbye to their loved ones prior to the multi-organ procurement surgical procedure.

1.3.2 Donation after cardiac death (DCD) or non heart beating donors

Worldwide, donation after cardiac death (DCD) first occurred prior to the introduction of brain death diagnosis, however in recent years there has been a reemergence of this type of donor (Coleman, Brieva & Crowfoot, 2008; Chapman, 1992; McGovern, 2009). Previously these donors ceased to be used with the adoption of brain stem death; as utilising organs from brain dead donors had better organ viability success rates with the process of multi organ procurement procedures. Due to increased public demand and a shortage of organs, a focus on DCD donors as another source of procurement of organs has re-emerged to increase the donor pool and to alleviate donor shortages worldwide (Bernat, 2008). In countries where the concept of brain death is not recognised, donation after cardiac death donors are still used for the purposes of donation of organs for transplantation (Price, 2000). In Australia, according to the ANZOD Registry (2012) the first multi-organ DCD procedure was undertaken in South Australia in 2006 (p. 14). Since this time, other states have also undertaken these procedures as a means to maximize the opportunity for organ supply (John & Chen, 2008; Norman & Byrne, 2008).

Donation after Cardiac Death donors are certified dead using the criterion of “irreversible cessation of circulation of blood in the body of the person” (NHMRC, 2009, p. 1). These donors have previously indicated their intentions and consent to be an organ donor should withdrawal of cardio-respiratory support for the purpose of organ donation be required. Donation after cardiac death donors are usually on a ventilator in an intensive care unit and are not brain dead however as they will not recover from their illness a decision has been made to discontinue and cease their treatment to allow them to die. The withdrawal of cardio-respiratory support can occur in the intensive care unit (ICU), the preoperative holding area or in the operating suite prior to the multi-organ procurement surgery. Once cardio respiratory support has ceased a period of observation or a “stand down” period of no longer than 5 minutes is conducted by the medical team to ensure cessation of circulation has occurred. This is undertaken to confirm no palpable central pulse or the recurrence of spontaneous auto resuscitation takes place. This gives family members a very short time to say their goodbyes to their loved ones following the declaration of death as procurement surgery must commence immediately after this stand down period. If irreversible cessation of circulation does not occur within a 90 minute time frame, the patient must be returned to a prearranged area for end-of-life care as organ procurement surgery cannot proceed as a prolonged dying process can yield the organs less viable for successful transplantation (NSW Health, 2007, p. 7; NSW Health, 2011).

1.4 Organ donation: The “gift of life”

Generous individuals and families consent to organ donation in order to save other human lives. The decision to donate has been described as an act of altruism and human solidarity, an unselfish giving of a gift to save the life of another person (Siminoff, Burant & Youngner, 2004). The National Health and Medical Research Council (2007a) assert that “altruism is a universal human virtue that is extolled as part of our Australian culture” (p. 5). Regrettably, many families are faced with the decision to donate organs for transplant during a crisis situation upon hearing their loved one has died or is likely to die. Some earlier studies have shown that families have turned to medical staff; such as doctors and nurses to assist them to make the difficult decision to donate organs from their family member (Duke, 1998; Kiberd & Kiberd, 1992; Mongovan, 2003). Those families who believe in the positive aspects of organ donation at a time of grieving often contend that their loved ones will live on in the recipient (Haddow, 2004). These families viewed organ donation as a way of giving meaning to the death of the loved one (Lauritzen, McClure, Smith & Trew, 2001; Siminoff & Chillag, 1999). Similarly, Mongoven (2003) also found family members believed that supporting the donation of organs provided some sense to the sudden loss of a family member, they stated “we wanted to make something good come out of something that seemed senseless” (p. 90).

Various organ donation awareness campaigns have been launched using mottos to promote organ donation, deeming it as the ultimate “Gift of life” (Lauritzen et al., 2001). Earlier mottos such as “give the gift of life” have now broadened to “share your life; share your decision” (Mongoven, 2003) to “organ or tissue donation and transplantation matter” used to encourage families to talk about organ donation together (Faunce, 2009). This gift offers many people awaiting organ transplant the opportunity to live longer and improve their quality of life (Molzahn et al., 2003; Schnitzler, Whiting, Brennan et al., 2005).

Worldwide there are a limited number of organs donated which has inevitably led to a scarcity of organs for transplant (Levvey & Snell, 2008; Rager, 2004; Sanner, 2006). Factors relating to a shortage worldwide have been documented as an aging population, an increase in survival rates related to motor vehicle accidents and recent advancements in car safety equipment, medical advancement in trauma care and people not discussing their wish to be an organ donor with their loved ones (Haustein & Sellers, 2004; Lange, 1992; Lock, 2002a). A number of other factors have been reported such as; people having fears that doctors may just want their organs and will not care for them and make every attempt to save their life (Hyde & White, 2007); disfigurement, religious or cultural reasons, the time in which medical staff initiated discussion of organ donation or simply some people are opposed to donation and transplantation (Hyde & White, 2007; Mongoven, 2003; Sque, Long, Payne et al., 2008).

1.4.1 Barriers to organ donation

Although many families recognise the need for organ transplantation and the plight of people who are in end stage organ failure, some families still choose not to donate their loved ones organs, as their immediate concern is that of honouring their dead relative (Barber, Falvey, Hamilton et al., 2006; Downie, Shea & Rajotte, 2008; Mongoven, 2003). Similarly, a more recent study by Sque et al. (2008) reported that families were concerned with the treatment of their deceased loved ones; they were concerned about the wholeness and integrity of their relative's body, perceived desecration of the their loved one's body being 'cut-up as spare parts'; that protecting their loved one's body was an important factor for relatives and was a major barrier to donation and hence declining organ donation as a result (Thompson, Robinson & Kenny, 2004; Tuttle-Newhall, Collins, Kuo & Schroeder, 2003).

Other barriers to organ donation and transplantation relate to religion and culture. Although, several religions have not indicated an objection to organ donation, various religions have reported differing cultural and spiritual practices at the time of death which may preclude organ donation and transplantation to be an accepted practice (Minniefield, Yang & Muti, 2001; Stephens, 2007). For instance, many cultures such as the Orthodox and Jewish religions require the deceased to be buried before sundown on the day of the death (Bruzzone, 2008; Lynch, 2005; Mongoven, 2003; Sque et al., 2008). In America, Native American tribes have been reported as rejecting organ donation as they believe organs will be required for the next animal reincarnation (Bruzzone, 2008; Fahrenwald & Stabnow, 2005). Some Christian religions assert that all organs are required at death when the body is resurrected. The National Health & Medical Research Council (2007a) affirms that some Australian and Torres Strait Islanders may have incompatible traditional beliefs about organ donation, transplantation and rituals at the end of life (Lange, 1992; Mongoven, 2003; NHMRC, 2007a; Stephens, 2007).

1.5 Establishment of organ procurement and transplantation surgery in Australia

In Australia, donation of organs and tissue for the use in transplantation were undertaken as early as the 1940s; notably the first corneal transplant in 1941 in a Queensland Hospital (Chapman, 1992), followed by successful liver, pancreas; lung and bone marrow transplants in the 1960's. In Australia, the first heart transplantation was attempted in 1968 at St Vincent's Hospital in Sydney however it was unsuccessful with the recipient who survived only 45 days post operatively (Chapman, 1992). Success in heart transplantation surgery was only achieved in 1983 with the establishment of the National Heart Transplant Unit at St Vincent's Hospital in Sydney, New South Wales. Further heart transplant centres were established in Melbourne at the Alfred Hospital in 1989; Prince Charles Hospital in Brisbane in 1990 and the Royal Children's Hospital in Melbourne in 1990 supported by government funding across Australia. Liver transplant centres were also established; in Sydney at Royal Prince Alfred in 1986; The Austin in Melbourne in 1988; Flinders Medical Centre, Adelaide in 1992 and; Sir Charles Gairdner Hospital in Perth in 1994 (Hirsch, Hailey & Martin, 1995).

1.5.1 *Organ donation in Australia*

Australia has an “opting in” system for donor registration which means that every Australian citizen is given the option to decide whether they wish to donate their organs. This intention is recorded by the National Australian Organ Donation Register which was established in 2005 and is overseen by Medicare Australia on behalf of the Australian government. The recently created national register includes the change from indicating your intention to donate, to a register of consenting and objecting to donation (NHMRC, 2007a). The NHMRC (2007a) has estimated that 801,000 Australians have registered their consent to donation. However, according to Thomas & Klapdor (2008) consent is not a legally-binding directive as each state and territory has different practices on proceeding to allow donation to take place. Moreover, within the Australia system families have the right to override and withdraw a patient’s consent and decision to donate regardless of their recorded “yes” indicated on their driver’s license. Therefore, regardless of a patients expressed wish to donate via a registered consent form, organ procurement generally does not proceed without familial consent (Australian and New Zealand Organ Donation Registry, 2006; NHMRC, 2007a; Tarrant, 2005; Standing Committee on Uniform Legislation and Intergovernmental Agreements, 2000).

Australia has recognised the successful outcomes and donation rates from other countries that have been quick at establishing nationally consistent processes and systems which have incorporated both local hospitals and providing support to health professionals in the work of organ donation and transplantation (NHMRC, 2007a). In recognition of this, the Australian government has sought to establish itself as a world leader in best practice in organ and tissue donation for transplantation by investing Commonwealth funding and implementing nationally consistent procedures. Since the establishment of the National Australian Organ Donor Register further work has been undertaken in building the National Organ Donation Collaborative (NODC) in 2006. The NODC is made up of 26 hospitals with teams of qualified health professionals to promote best practice models and develop evidence based guidelines and interventions to promote organ donation and transplantation. The work of establishing a national system was undertaken from 2006 with drafts of various policy, procedures and legislation relevant to organ and tissue donation being formulated and reviewed by the Commonwealth government (NHMRC, 2007a; Thomas & Klapdor, 2008).

1.5.2 *The demand for organs in Australia*

Increasing the availability of organs has become a priority for the Australian government in an effort to reduce chronic dependence on organ replacement technologies and improve the quality of life for those with end stage organ disease. Consequently there has been a strong focus on identifying potential donors for organ and tissue donations (Levvey & Snell, 2008; Stephens, 2007). According to the Australian and New Zealand Organ Donation Registry (2012) the rates of public support for donation have been suggested at 90% however there is still a great disparity in Australia between the amount of organs required and the amount donated (ANZOD Registry, 2012). To alleviate this, recent governments

have allocated 134 million dollars to improve organ and tissue donation and transplantation systems for the Australian community. One of the biggest problems identified in Australia has been the fragmented approach to organ donation and transplantation, as there has been no uniform Commonwealth legislation concerning organ donation. Therefore as a nation there has not been one coordinated approach to organ donation and transplantation which means that each state and territory have practiced under separate legislation, laws and policies governing consent for organ donation and transplantation (Thomas & Klapdor, 2008).

Australia when compared to other western countries has one of the highest success rates for organ transplantation surgery. However it also has one of the lowest organ donation rates in the world (ANZOD Registry, 2012). Subsequently, this has led to longer waiting periods for Australians requesting transplants, with some patients dying before an organ becomes available. One successful multi organ procurement surgery has the potential to save the lives of at least six individuals. However, low donation rates in Australia continue to hamper efforts to save lives. Today, within Australia the demand for various organs is rapidly rising as the population ages and survives to end stage chronic conditions which subsequently increase transplant waiting lists. Several authors have documented the needs of particular patients waiting for lifesaving organs such as kidneys (Mathew, Faull & Snelling, 2005) and the demand for paediatric organs (Keating, Westall, Marasco et al., 2008). Recently released data by the ANZOD Registry (2012) reported that within Australia 1,518 people were on the waiting list in need of organs, specifically kidney, liver, heart, heart and lung, lung, pancreas, pancreas islet and intestines.

With this demand, an increased need for suitable donors who can provide multiple organs has also risen. Since the introduction of DCD multi-organ donors, an increase of procurement procedures and multiple organ donations has been reported (ANZOD Registry, 2012). Previous statistics showed a decline in donation rates and multi-organ procurement procedures such as; in 2005, 29 cadaver donor patients underwent multiple organ procurement surgery within Western Australian Hospitals and 54 within New South Wales Hospitals (ANZOD Registry, 2006, p. 21). The following year 2006, 21 multiple organ retrievals were conducted within Western Australia Hospitals and 50 within New South Wales Hospitals (ANZOD Registry, 2007, p. 22). Statistics for 2007 indicate that in Western Australia 19 multiple organ procurement procedures were undertaken with 53 in NSW. Donation rates and the demand for multi-organ procurement surgical procedures improved when both types of donors (brain dead and DCD donors) were utilised. Statistics from 2011 indicate an increase in multiple organ procurement surgical procedures, with 33 undertaken in Western Australia and 77 in New South Wales (ANZOD Registry, 2012, p. 25). The improvement in donation rates and the demand for organs is indicative of the need for these procedures to be undertaken as the increased demand for organs continues. However, this situation leads to added pressures and stress on transplant teams to ensure that procurement of organs is a success as these organs are vitally required and are in short supply.

1.6 Contextualising the study: Perioperative nursing and procurement literature

Although it is common practice to not undertake a literature review when using grounded theory methodology until later in the research process (Glaser, 1998), a preliminary literature review was undertaken to meet the initial obligations of the research proposal submission guidelines and to identify gaps in the literature to justify the need for the research study in the related subject area. To contextualise the study, a background of relevant literature was sought to understand the existing knowledge in the area and identify gaps. Therefore, the literature review sought to provide a broad overview of contemporary scientific literature on perioperative nurses' involvement in procurement surgery in order to identify possible issues and challenges that impact on their professionals practice when undertaking procurement surgical procedures. Literature was sought through the relevant national and international databases for the period of 1960-2007 using a combination of key words. Only four international studies were located specific to perioperative nurses' involvement in procurement surgical procedures, therefore the search was broadened to cover other perioperative nursing issues and challenges which could closely relate to procurement surgery. This context includes; the perioperative nurses' role in multi-organ procurement surgical procedures, the multi-organ procurement surgical procedure, perioperative nurses' experiences in procurement surgical procedures, health professional's attitudes to organ donation and procurement surgery, psychological distress and work related trauma, exposure to death and trauma and collaboration of health professional's during procurement surgery.

1.6.1 *The perioperative nurses' role in multi-organ procurement surgical procedures*

Historically, the perioperative nurse has been a prominent member of the surgical team dating back as early as the civil war in America (Holder, 2004). Perioperative nurses first began work operating in patient's homes, preparing a room for operating in, boiling sheets and instruments (McGarvey, Chambers & Boore, 2000; Oetker-Black, 1993; Rogers, 1970). They have worked in makeshift tents at field hospitals during wars and have become an integral part of the modern operating theatre team, including the administration of sophisticated multi-suite surgical theaters in modern tertiary hospitals (McGarvey et al., 2000; Phillips, 2004; Riley & Peters, 2000; Tanner & Timmons, 2000). These nurses have witnessed advances in modern medicine from the development of anesthetic agents, to improved techniques in asepsis, sterilisation and the introduction of new specialised surgical techniques and instrumentation (Hamlin, Richardson-Tench & Davies, 2009; Oetker-Black, 1993; Rothrock, Smith & McEwen, 2003).

The introduction of modern medicine has expanded the scope and role of the perioperative nurse and the cases they will be involved in. Perioperative nurses have continued to work collaboratively within surgical teams in operating suites assisting in the surgical repair of bodily organs to preserve life (Hamlin et al., 2009; McGarvey et al., 2000; Phillips, 2004; Rothrock et al., 2003). They work with patients who are injured, suffering from disease as well as patients who are close to death (Rothrock et al., 2003; Sigurdsson, 2001). Their roles have expanded in line with advanced surgical practice which has moved beyond the

repairing of dysfunctioning organs to procuring and transplanting organs such as the procedure of multi-organ procurement and transplantation surgery (Fox, 1999). Today, perioperative nurses continue to participate and provide intraoperative assistance to procurement teams undertaking multi-organ procurement surgery at the time these procedures are required (Carter-Gentry & McCurren, 2004; Regehr, Kjerulf, Popova & Baker, 2004).

In Australia, typically there are no dedicated nursing teams for procurement surgery, therefore these cases are undertaken by the available operating suite nursing staff at the time these surgical procedure are required. This places enormous pressure on staff to participate in these procedures, often at short notice and at times with no prior experience and no formal education or preparation. When a multi-organ procurement procedure is instigated, the hospital based teams prepare the donor for the procurement surgery. These hospital based teams consist of an anaesthetist and three perioperative nurses in the role of a scrub nurse, a scout nurse, anaesthetic nurse or an anaesthetic technician. At the same time external procurement teams of surgeons travel from the site where the donations will be implanted to work with the hospital based teams during the retrieval procedure. The external procurement surgeons have a very definitive objective to obtain and preserve body parts for successful transplantation to a recipient(s) elsewhere. Hospital based teams facilitate this objective however also have the responsibility to care for the donors body with dignity and respect. It is important to highlight that the various external procurement teams are unknown to nurses in the operating suite or hospitals and only come to work together for the duration of multi organ procurement surgical procedure. These surgical procedures are fast paced, technical, stressful in nature and can take an average of between five to six hours (Lilly & Langley, 1999; Regehr et al., 2004). Hence, it requires the collaborative efforts of perioperative nurses, procurement and transplant surgeons and surgical teams to ensure that organs are removed in a timely manner within adequate organ preservation times (Hawke, Kraft & Smith, 1990). This special area of practice requires the perioperative nurse to be skilled, prepared, knowledgeable and able to function well during intense and potentially stressful surgery. These nurses must also balance the emotional demands of dealing with the delicate nature of death while assisting in the procurement of organs to be used on a waiting recipient(s).

1.6.2 The multi-organ procurement surgical procedure

Multi-organ procurement procedures occur when donors have two or more organs retrieved for the purposes of transplantation (ANZOD Registry, 2012). The retrieval of organs and tissues is undertaken as a full surgical procedure. The donor is positioned on the operating room table and prepped for the commencement of surgery; a midline incision is made from the suprasternal notch down to the symphysis pubis. An abdominal team commences the abdominal dissection and mobilisation of the liver, pancreas and kidneys are undertaken along with cannulation of various major blood vessels. The cardiothoracic surgical team follows who scrub in and mobilise the heart and lungs and cannulate further vessels. Once this is complete the aorta is cross clamped, cardioplegia and preservation fluids are infused into the organs. The ventilator is switched off to cause spontaneous

asystole if the patient is a heart beating donor (brain dead donor). All monitoring and infusions are switched off and venting of the donor blood occurs. The surgeons then proceed to remove the heart and lungs, followed by the liver, pancreas and kidneys. The organs are further dissected, inspected and immediately triple bagged in preservation fluid, then placed in ice slush in eskies for immediate transport to a receipt awaiting the organs. Organ preservation must be maintained until they are retrieved and utilised for transplantation, any organs deprived of oxygen will degenerate and will not be effectively viable for transplantation (ANZOD Registry, 2012; Lamb, 1990). For optimal organ function after transplantation, common preservation times and transplantation vary for each organ; a heart and lung must be transplanted between 4-6 hours after recovery, liver and pancreas 12 hours and kidneys within 24 hours. Bone and corneal harvesting can be undertaken after the procurement of solid organ either within the operating room or later in the morgue.

1.6.3 Perioperative nurses' experiences in procurement surgical procedures

Like many other surgical procedures the role of the perioperative nurse has been integral in the success of procurement procedures. For these nurses, gaining experience and exposure to procurement surgery only occurs when they are required to be involved in such a procedure. This involvement often occurs at short notice (Fox, 1999). Previous international research has suggested that nurses working within surgical procurement teams may experience a variety of emotions following the experience. Operating suite nurses' experiences of working in multi organ procurement surgery teams has been reported as highly stressful, with effects of personal distress, strained relationships with visiting surgical teams and negative attitudes to organ donation as a result of participating in multi-organ procurement surgery (Carter-Gentry & McCurren, 2004; Lloyd-Jones, 1996; Page, 1996; Regehr et al., 2004; Wolf, 1991).

Whilst the perioperative nurse in the Australian context is not likely to be directly involved with the families of donors or recipients, other than during a DCD procedure they nonetheless experience emotions of sensitivity towards their patients and significant others. International research has strongly emphasised that for perioperative nurses in the operating room specialty, participation in procurement surgery initiated difficult emotions for the nurses involved (Page, 1996). These emotive feelings included grief towards the donor, the donor's family members, sympathy, anger, sadness, helplessness and coping with emotional blunting during the procedure (Page, 1996; Regehr et al., 2004). A Canadian study by Regehr et al. (2004) described that nurses were both physically and emotionally drained as the surgical procedures were fast paced, intense, continued for long hours with little opportunity for the nurses to take a break. Further it was reported that these procedures were often conducted late at night where fewer nursing staff were available for support. Others have reported that perioperative nurses viewed participation in organ procurement surgery as disrespectful, traumatic and emotionally draining (Carter-Gentry & McCurren, 2004). It was described by one nurse that consequences of participating in the donation process included feeling emotionally drained and having difficulty sleeping because of re running the experience in his mind (Kent, 2004).

1.6.4 *Health professional's attitudes to organ donation and procurement surgery*

Attitudes to organ procurement surgery from the perspective of health professionals involved in these procedures have been reported widely. A predominant finding from earlier research identified that health professionals participating in organ procurement procedures were less likely to willingly donate their own organs after death (Duke, Murphy & Bell, 1998; Gaber, Hall, Phillips et al., 1990; Gross, Marguccio & Martinoli, 2000; Kent & Owen, 1995; Randell & Marwick, 1991; Stoeckle, 1990; Youngner, Landefeld, Coulton et al., 1989). This attitude continues to be reported in more recent research studies (Boey, 2002; Kim et al., 2004a). Within the nursing profession, research into attitudes of emergency room nurses (Kennedy & Farrand, 1996); critical care nurses (Duke et al., 1998); and ICU nurses (Stark et al., 1984) all confirmed that these nurses were also less likely and willing to donate their own organs upon their death. Dominant findings amongst these studies were concerns that the donor was treated with little dignity and respect which initiated negative attitudes towards donation. These health professionals found it difficult to deal with the grief and loss of life of the donor. Procurement procedures for health professionals were also reported as creating extra work and stress for the team members involved (Gross et al., 2000). A concern from these findings was the reported negative attitudes towards procurement held by these health professionals as it was viewed they may undermine organ procurement efforts if they chose to not promote donation of organs to potential donor's family members.

1.6.5 *Psychological distress and work related trauma*

Psychological distress related to organ procurement is an area which is poorly understood from the perspective of health professionals as these procedures may potentially affect those working closely with in this field of work. Currently, there is no research which has explored the long term effects on individuals who frequently participate in these procedures. There is a significant body of literature which has reported the impact of work related traumatic incidents on emergency worker professions such as police officers, ambulance officers, fire fighters, emergency physicians, nurses and social workers (Adams, Boscarino & Figley, 2006; Alexander & Klein, 2001; Brough, 2004; Taylor, Pallant, Crook et al., 2004). Stressful work situations and reactions have been studied from various perspectives using various research methods. Several authors have documented that workers exposed to traumatic events as part of their duties experience emotional stress reactions which are outside of the average person's experiences (Brough, 2004; Regehr, Hill & Glancy, 2000). Research on emergency worker professions has reported high stress levels, high absenteeism, psychological distress and psychological health consequences (Jenkins & Baird, 2002; Lerias & Byrne, 2003; Regehr, 2001; Regehr, Hemsworth & Hill, 2001; Soderfeldt et al., 2000). Stress reactions amongst these professionals have been identified as immediate and long term stress reactions. Symptoms experienced included irritation, annoyance, anger, sadness, grief, numbness, avoidance of places or things that remind them of the trauma, denial, withdrawal from social interaction, depression, anxiety, difficulty with memory and concentration. Further symptoms have been reported to include fearfulness, dread, irritability, sleep disturbance, flashbacks, depression and post traumatic stress disorders (Jenkins & Baird, 2002; Lerias & Byrne, 2003; Regehr, 2001;

Regehr et al., 2001; Soderfeldt et al., 2000). In relation to procurement surgery, all of these signs and symptoms have been alluded to in the previous international literature and would therefore suggest the potential for perioperative nurses to experience similar symptoms when participating in procurement surgery.

1.6.6 *Exposure to death and trauma*

Exposure to death and trauma has been identified as a major source of stress related to multi-organ procurement surgery. Dealing with death in the operating suite is an infrequent occurrence however, when death does occur in the operating suite setting, it is dramatic and disturbing for the surgical team who witnesses it and is often viewed by staff as a defeat or failure (Aroskar, 1991; De Leval, 2004; Jefferies, 1993; Younger et al., 1985). As reported by Wolf (1991) organ procurement surgery is performed not to prolong the life of a donor in contrast to other surgical procedures undertaken within operating rooms. Studies by Gillespie & Kermode (2003) and Goldstone, Callaghan & Mackay et al. (2004) have identified the death of a patient as a source of stress for surgical team members however, these studies have not included the effects on perioperative nurses or surgical teams caring for deceased donors whilst undertaking multi organ procurement surgery. Another aspect of procurement surgery which perioperative nurses found difficult was reported as providing post-mortem care to organ donors after a procurement procedure (Wolf, 1991). The operating suite setting was reported as an unusual setting to conduct post-mortem care. In the study by Wolf (1991) one nurse “compared procurement surgery to an autopsy” (p. 84). It was noted that nurses reacted to post-mortem care by blocking their emotions in order to deal with death and post-mortem care. These nurses reported that giving post mortem care caused them to be uneasy, drained, exhausted and were upset by the experience and found it difficult to forget the event for a few days afterwards (Wolf, 1991).

1.6.7 *Collaboration of health professional's during procurement surgery*

Recent research suggests that effective partnerships and collaboration between nurses and physicians within the specialty of operating rooms is an essential requirement for safe patient care (Sterchi, 2007). Healey, Undre, Sevdalis et al. (2006) state that the level of teamwork may enhance or hinder the level of care provided to patients. However, in relation to organ procurement a major source of stress was reported as strained relationships with procurement teams (Lloyd-Jones, 1996; Page, 1996; Regher et al., 2004) which raises concerns for the individuals participating in these procedures. Previous researchers have commented on the need for procurement professionals to introduce themselves to the hospital staff within the operating rooms (Lloyd-Jones, 1996; Regher et al., 2004) as procurement teams are usually unknown to nurses in the operating suite until these procedures take place. Therefore these teams have to work closely at short notice, under extreme pressure of fast paced surgery, without prior knowledge of the various procurement teams' preferences of instrumentation and equipment required for the surgery. Regher et al. (2004) reported that nurses were treated disrespectfully and had instrumentation thrown at them by procurement teams. Similar concerns were mirrored in the study by Page (1996) who identified that visiting procurement teams demanding equipment and assistance of the perioperative nurses caused increased anxiety for the

nurses involved in these procedures with interactions and strained relationships causing added stress and anxiety for the nurses. Nurses preferred everyone involved in the procurement procedure behave professionally and with dignity however research has identified that this may not always be the case during procurement surgery (Lloyd- Jones, 1996; Page, 1996; Regehr et al., 2004).

1.6.8 Deficits in current literature

Currently, there is limited international research on multi organ procurement surgery pertinent to the perioperative nursing specialty, with no studies reported within an Australian context. The existing literature has provided research evidence conducted at examining the attitudes of perioperative nurses on organ procurement, their experiences and the effects of participating in such procedures. However, the predominant findings of previous research indicate that nurses undertaking multi-organ procurement procedures reported negative experiences towards their participation. A gap exists within the literature which explores the education and preparation for these nurses to undertake these procedures. The majority of studies related to the proposed research study are outdated, with most conducted some 11-16 years ago (Lloyd- Jones, 1996; Page 1996; Wolf, 1991). These studies are also limited in that they have examined perioperative nurses within one hospital setting and have been conducted in America, Canada and England where it has been recognised that different medical services are provided. Hence, these studies raise questions about the validity of their findings in a broader context and whether these findings will apply to other operating rooms and perioperative nurses in clinical settings both locally and internationally (Carer-Gentry & McCurren, 2004; Lloyd- Jones, 1996; Page, 1996; Regehr et al., 2004; Wolf, 1991). Moreover, these earlier studies have attempted to explain various issues which impact on the nurses experiences however fail to delve deeper into the social and psychological processes and interactions of the perioperative nurses experiences when working in multi organ procurement surgical teams.

The experiences, needs and individual well-being of perioperative nurses in addition to their abilities to function together with procurement professionals and the surgical team during stressful surgery is an area which requires further exploration. It has been highlighted within the literature (Lloyd- Jones, 1996; Page, 1996; Regehr et al., 2004) that visiting surgical teams were viewed as a source of stress and tension within operating rooms however this has not been explored further. Currently, there is no literature which reports how these nurses are prepared or debriefed to undertake these procedures and how they manage problems they encounter as they fulfil their roles in these surgical procedures.

As the demand for organs and subsequently organ procurement procedures continues to increase there is a greater need to better understand the impact on nurses and the surgical teams participating in these procedures. Further research is indicated to explore and fully document the perioperative nurses experience of working in multi-organ procurement surgical teams, as well as to understand the experiences of these nurses so as relevant solutions can be found to make multi-organ procurement surgery a more positive

experience for perioperative nurses and the surgical team as a whole.

1.7 Purpose of the study

The purpose of the study is to generate a substantive theory that explains the experience of perioperative nurses working in multi-organ procurement surgical procedures. The study will be conducted at multiple hospital sites within Western Australia and New South Wales to ensure theoretical understanding of perioperative nursing work surrounding organ procurement. The findings will be compared with existing international literature to identify similarities and differences as well as new aspects of the experience. The findings will provide clinicians, health educators, and policy makers with a greater understanding of how multi-organ procurement surgery impacts on perioperative nurses and other members of the surgical team.

1.8 Research study objectives

The objectives of this study are, in the Australian context, and from the nurses' perspective to:

1. Explore and describe the experience, psychological, social processes, interactions and how these impact on nurses participating in multi organ procurement surgical teams
2. Identify factors that facilitate or inhibit the experience of nurses' involvement in multi-organ procurement.
3. Ascertain the interrelationships between the nurse and procurement surgical teams.
4. Generate a substantive theory which fully documents the experience and places it within the context of relevant theoretical literature.

1.9 Need and significance of the study

Organ procurement and transplantation continues to be an expanding area in healthcare. Advances in technology and procurement procedures within the transplantation field have expanded since its first inception in medicine. Medical advances in transplantation made over the last decade have given hope to many patients suffering end stage organ failure. These patients are eagerly awaiting an organ for both a lifesaving and life transforming benefit. Legislative changes and medical advances have improved the potential donor pool via donation after cardiac death and brain dead donors. This inevitably will lead to additional donors which will maximise organ procurements opportunities through multi-organ procurement surgical procedures.

Australia has recognised the need to establish nationally consistent processes and systems which incorporate both local hospitals by providing support to health professionals in the work of organ donation and transplantation. The Australian government has sought to establish itself as a world leader in best practice in organ and tissue donation for transplantation by investing Commonwealth funding to increase resources and training of

health professionals and the community to facilitate increases in organs procured and transplantations for the Australian community (Organ & Tissue Authority, 2010).

Currently there is a dearth of contemporary research literature worldwide and within an Australian context which examines in depth the perioperative nurses role and experiences whilst participating in multi-organ procurement surgery. Little is understood of the perioperative nurses experiences, psychological impact, and the immediate and long term psychological health consequences of those working closest to the process of donors having multi-organ procurement surgical procedures. It is timely, that this group of health professionals is acknowledged for the unique contribution they make towards organ and transplantation successes. The perioperative nurse is pivotal to successful multi-organ procurement procedures to meet the demands of organs urgently required by waiting recipients.

Currently, organ donation and transplantation continues to be an expanding area in healthcare which has yet not been explored within an Australian context and from the unique perspective of the perioperative nurse. This study will be the first of its kind, to develop a substantive theory describing the experiences of perioperative nurses and will provide new insights into their experiences and professional interrelationships when participating in multi organ procurement surgery.

The results of this study will be significant to perioperative nurses, surgical teams, procurement organisations and hospital organisations to establish the nature of nursing work in this specialised area of health care and make necessary recommendations as appropriate. The findings of this study will be timely in addressing the need to emphasis current work practices and experiences of the perioperative nurse participating in multi-organ procurement surgery. Further, the findings will make a new contribution to the knowledge and understanding of working within multi-organ procurement surgical teams that will have an impact on patient care outcomes, education and support resources for perioperative nurses. Therefore, these findings have the potential to influence nursing education, health policy, clinical practice and organisational support structures available to support perioperative nurses and other health care professionals in the clinical settings.

1.10 Summary

The practice of organ donation and the success of organ procurement surgery worldwide has been widely reported. In the year 2012, organ procurement surgery is a widely promoted medical intervention treating conditions such as end stage organ failure or disease which inevitably may lead to impending death for an infant or adult alike. The work of organ transplantation is only made possible by organ donors providing their organs upon their death to be dissected and implanted into numerous recipients waiting for specific organs on many transplantation waiting lists. There is a growing awareness of the benefits of transplantation in both healthcare and the community abroad and within Australia. Despite this, little attention has been paid to the perioperative nurses' contributions to

multi-organ procurement surgery in Australia. The following Chapters will present this research study.

1.11 Overview of the thesis

This thesis presents the research study and is comprised of eight chapters. Chapter 1 provides background information regarding the history of organ donation and transplantation worldwide and within an Australian context. A brief overview of literature pertinent to the study topic is presented. It discusses the role of the perioperative nurse in these surgical procedures to set the scene for the study. Further, this chapter outlines the research purpose, the study's need and significance and research objectives. Chapter two describes the use of the grounded theory methodology and the use of this method towards undertaking the research process.

The following four Chapters, chapter's three to six details the substantive theory. Chapter three outlines the identified basic social psychological problem of *hiding behind a mask* which was described as the participant's main concern. Chapter four presents the conditions influencing the basic social psychological problem of *hiding behind a mask*. Chapter five outlines the identified basic social psychological process of *finding meaning* which was what participants did to resolve their main concern. Chapter six presents the conditions influencing the identified basic social psychological process of *finding meaning*.

Chapter seven presents a discussion of the substantive findings with a comparison of relevant scientific literature and theories. This discussion looks at other theories within other fields to position the theory amongst the scientific literature. Further, a closer look at previous research in the substantive area is also compared to illustrate the relevance of the study findings and the developed substantive theory. Lastly Chapter eight presents a discussion of the relevance and significance of the study findings by providing relevant research recommendations to perioperative nurses, health services, professional perioperative nursing organisations and government organisations to highlight and address the study findings. Lastly, a discussion of the limitations of the study is provided and finishes with a concluding statement of the thesis.

CHAPTER 2

The Grounded Theory Research Methodology

“The goal of grounded theory is to generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved” (Glaser, 1978, p. 93)

2.1 Introduction

This chapter presents and describes the methods utilised to conduct the study investigating the experiences of perioperative nurses’ participating in multi-organ procurement surgical procedures in both New South Wales and Western Australia. It begins with a discussion on the choice and use of qualitative research for the study and the rationale for the use of the grounded theory methodology. An overview of the historical development of grounded theory is provided as well as a detailed description of the method used to conduct this study. The steps the researcher took in obtaining ethical approval prior to going into the field is also presented along with a discussion of procedures used to recruit and sample participants. Furthermore, the collection and analysis of data to generate a substantive theory is described. The chapter concludes with a discussion of the steps undertaken to ensure the methodological rigour has been adhered to, pertinent to the study.

2.2 Qualitative research

Qualitative research is widely used in many disciplines, for example, sociology, psychology and nursing and has imparted new ways of viewing situations, people and events. These experiences are provided by the inclusion of participant’s commentaries, quotations and stories by presenting the varied array of multiple realities and viewpoints of the participants (Dey, 1999; Streubert Speziale & Carpenter, 2003). Qualitative research methods are varied and the choice of the qualitative research approach is dependent on the research problem and purpose (Punch, 2005; Rapport, 2003). There are various qualitative research approaches which include Phenomenology, Ethnography, Action Research and Grounded Theory. The different methodologies are all unique but all have some commonalities and differences in data collection methods, analytical strategies of coding, sorting and sifting of data and seeking patterns or processes (Punch, 2005). A qualitative researcher must learn to see, hear, perceive and understand in new ways (Hill, 2007). Denzin and Lincoln (2005) describes three distinctive processes in choosing a qualitative approach referring to these as ontology, epistemology and methodology. Ontology questions the nature of reality; epistemology questions what the relationship between the inquirer and the known is and methodology seeks to understand how we know the world, or gain knowledge of it. This questioning shapes the researcher’s choice and selection of a method and theoretical perspective.

Qualitative research is therefore a method used to gain a deeper understanding of a social setting or activity from the emic or individual’s perspective. The research approach looks at complex situations exploring participants in a setting or a process as they experience it with

emphasis on the participant's meanings and interpretations of the experience by reflecting on their reality (Bloomberg & Volpe, 2008; Morse & Richards, 2002). Therefore there is an emphasis on uncovering the thoughts, perceptions and feelings experienced by participants and how these in turn influence their actions (Minichiello, Aroni, Timewell & Alexander, 2000).

Qualitative research can also be used when exploring an area where little is known about the subject area or where there is an identified dearth or gap in the literature about a certain phenomenon (Maxwell, 2005). Denzin and Lincoln (2005) state that qualitative researchers study things in their natural settings while attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2005, p. 3). The objective of the qualitative researcher is to capture the participant's perspective by providing a rich description of the experiences encountered in data collection and analysis (Sandelowski, 2004). The researcher, in a qualitative inquiry is an instrument; hence the researcher is part of the study as an observer, interviewer or interpreter of aspects of the inquiry (Streubert Speziale & Carpenter, 2003). According to Denzin and Lincoln (2005) "qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (p. 10).

Given the broad choice of qualitative research methodologies available, the researcher choose the grounded theory method for this study as this was viewed to be the most suitable method to explore the experiences of perioperative nurses assisting in multi-organ procurement surgery. The impetus for this choice was to focus predominantly on the research area as there is little that is known about the phenomenon of multi-organ procurement surgery from the perspective of perioperative nurses. It was also chosen to accurately understand and detail the psychosocial experiences of perioperative nurses and the impact of these experiences on the nurse's well-being and that of the surgical team undertaking multi-organ procurement surgical procedures. This form of approach was not only chosen to provide a descriptive analysis of the individual nurse's experience but to assist in understanding the social and psychological culture of the operating room environment and the surgical team dynamics when undertaking these surgical procedures. This methodology also allowed the researcher to identify the main concern of the participants as well as the behaviours and actions they used to resolve their concerns. Finally, with limited literature and research available within the field, the researcher felt it was important to choose an inductive methodology to firstly explore and conceptualise the interactional processes and to generate a substantive theory grounded in the data and compare this with existing literature that has relevance to perioperative nurses.

2.3 The grounded theory method

As noted grounded theory is a qualitative research method used for theory development which is grounded in the data that has been systematically gathered and analysed. The development of a theory explains patterns of behavior or the main shared concern from the perspective of the study participants (Glaser & Strauss, 1967). As described by Morse

and Field (1995) grounded theory has a purpose of generating an explanatory theory of human behaviour. According to Glaser (1978) grounded theory research has made it possible to study the meanings of events for people. This is based on the assumptions that these meanings are shared via a common language and socialisation (Chenitz & Swanson, 1986). The grounded theory method as originally described by Glaser & Strauss (1967) is primarily an inductive research method; that is the researcher is continually guided by the data, its codes and categories to identify the emerging substantive theory (Glaser, 1992). Grounded theory also uses deductive strategies to study the basic social and psychological processes and interactions around a specific phenomenon or problem during theoretical sampling which Glaser (1998) asserts directs the researcher “where to go next for data to compare” (p. 43). The method allows the discovery of underlying elements and patterns of interactions and social processes of the phenomenon under investigation (Denzin & Lincoln, 2005). Most importantly, grounded theory is also a method used to generate new theory and understanding about a phenomenon, rather than testing a previous theory (Punch, 2005; Streubert Speziale & Carpenter, 2003). Moreover, its approach is useful when very little is known about a topic or study area in which little or no research has been conducted or to gain a new viewpoint in a research area (Holloway & Todres, 2006).

Grounded theory can produce two types of theories, either a substantive or a formal theory. A substantive theory has a focus on a specific process and is developed for a narrower empirical area of study such as the focus of this current research on the perioperative nurses experiences participating in multi-organ procurement surgery. A substantive theory can be used to further build a formal theory. A formal theory is more general and deals with a conceptual area of inquiry that can be related to a broad range of other substantive areas (Glaser, 1978). According to Glaser and Strauss (1967) both theories are classified as “middle - range theories” and although narrower in scope are relevant to the people concerned and can be easily modifiable, provide valuable insights of reality which can lead to a linkage of theory and practice (Glaser & Strauss, 1967, pp. 32-33).

The aim of grounded theory is to explain from the participant’s perspective “what is going on” this enables a theory to be developed from the data obtained. According to Glaser and Strauss (1967) grounded theory moves through four research processes: 1) data collection; 2) data analysis; 3) theory generation and 4) writing the theory while using the process of constant comparison analysis (1967, p. 104). However, these stages of the research process can all occur simultaneously which entails the researcher having to move back and forth between data collection, data analysis, theory generation and lastly writing the theory (Glaser & Strauss, 1967). A more detailed explanation of the research process related to the research study and the application of the grounded theory method used in this study is provided later in this chapter.

2.3.1 Historical development of grounded theory

Grounded theory was developed in collaboration by the imminent American sociologists, Barney Glaser and Anslem Strauss (1916-1996) whilst working at the University of

California, San Francisco USA, in the School of Nursing for the newly developed nurses' doctoral program (Stern & Covan, 2001). The method was first documented in their classic work on dying which produced two books *"Awareness and Dying"* (Glaser & Strauss, 1965) and *"Time for dying"* (Glaser & Strauss, 1968). The grounded theory method was formalised whilst sharing their methodological steps used in their research in the publication of the book, *"The discovery of grounded theory"* in 1967. Within this book Glaser and Strauss (1967) emphasised the general method of comparative analysis, where they emphasised the need to generate theory from the data systematically rather than focussing on its verification or deducing testable hypotheses from existing theories. This they explained had been the norm in the 1960's by sociology researchers (Glaser & Strauss, 1967). Glaser & Strauss (1967) also emphasised that their text was intended to identify and generate sociological theory, emphasising "that *only* sociologists could do that" (Glaser & Strauss, 1967, p. 6). Although Glaser and Strauss (1967) envisioned the grounded theory method's use in the discipline of sociology, it gained widespread recognition and acceptance in other disciplines such as psychology, public health, social work and nursing (Streubert Speziale & Carpenter, 2003). Glaser and Strauss' (1967) work was viewed as revolutionary as they proposed an alternative research method which used an interpretive approach to knowledge construction, rather than the traditional quantitative empiricist approach (Benoliel, 1996; Glaser, 1992).

Both sociologists, Glaser and Strauss (1967) brought diverse backgrounds, training and perspectives to the development of the grounded theory method. Glaser trained in quantitative research methods from Columbia University focussing on theory construction from role theory and social structural theory (Glaser, 1998). He was taught and influenced by Merton, Lazarsfeld, Zetterberg, Hyman & Selvin (Schreiber & Stern, 2001). Strauss on the other hand was influenced by the works of Park, Thomas, Dewey, Mead, Hughes and Blumer and the work of symbolic interactionism (Schreiber & Stern, 2001). He studied and worked at the Chicago School of Sociology where he was a student of Blumer (Glaser & Strauss, 1967). The contribution to grounded theory by Glaser was the integration of quantitative methods into the methodology as well as establishing systematic coding and generating theoretical hypotheses to qualitative research (Schreiber & Stern, 2001). Strauss on the other hand contributed his training in qualitative methods and research studies using symbolic interactionism (Stern & Covan, 2001).

Symbolic interactionism has been described as the basic underpinning of grounded theory within the literature (Chenitz & Swanson, 1986; Hutchinson & Wilson, 2001). The original works on social behaviourism and the concept of mind and self by George Herbert Mead (1863-1931) lay the first foundations of the symbolic interactionist approach which later lead to the emergence of the discipline of symbolic interactionism which arose from the Chicago School of Sociology (Blumer, 1969; Morris, 1934). The term symbolic interactionism was coined by Herbert Blumer (1969) which is a major sociological perspective with an emphasis on a micro-scale of social interactions such as the nature of everyday human interactions. According to Blumer (1969) symbolic interactionism relies on three premises:

... human beings act toward things on the basis of the meanings that things have for them... that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows... that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (p. 2)

Both Glaser and Strauss (1967) believed there was a widening gap between theory and research with an emphasis on only verifying existing theory rather than generating new theory. As co-originators of the grounded theory method they were credited with bringing various differences and influences to the grounded theory method. This included generating a theory which was useful, relevant, fits empirical situations, is understandable, and provides relevant predictions, explanations, interpretations and applications (Glaser & Strauss, 1967).

2.3.2 The divergence of the grounded theory method

Although the grounded theory method gained popularity in its use amongst researchers, its method was to diverge when both Glaser and Strauss later parted company. This initiated a divergence of the method with the use of varying approaches and analysis (Cutcliffe, 2005; Walker & Myrick, 2006). This occurred in 1990 when Strauss co-authored and published the controversial text *"Basics of qualitative research: Grounded theory procedures and techniques"* with Juliet Corbin, a nurse researcher (Strauss & Corbin, 1990). Glaser (1992) wrote to Strauss to request he pull the book as there were numerous discrepancies from the original theory and as a result Strauss and Corbin had changed the grounded theory method and it could no longer be called grounded theory. Glaser further emphasised that Strauss and Corbin's (1990) explanation of the grounded theory method focussed on forcing the data rather than the data emerging from the coding procedure (Walker & Myrick, 2006). Strauss's response was that many researchers were struggling to understand the grounded theory method which required the techniques to be further clarified by emphasising verification using technical procedures rather than using the comparative methods of analysis (Strauss & Corbin, 1990). As a result of Strauss not removing the text from publication and acknowledging the discrepancies, Glaser set about correcting the discrepancies with his own text. Glaser (1992) published the text *"Basics of grounded theory analysis: Emergence vs forcing"* to detail his objections and to clarify his position on the methodology within the book by stating "thus it is up to me to write a cogent, clear correction to set researchers using grounded theory on a correct path to discovery and theory generation" (p. 3).

As both co-originators stand firmly on their interpretations of the methods of grounded theory it is now commonly accepted that there are two forms of grounded theory named after both co-originators; Glaserian and Straussian methods (Walker & Myrick, 2006). Although the grounded theory methods and divergent approaches have been acknowledged with some commonalities (Heath & Cowley 2004; McCann & Clark 2003; Walker & Myrick, 2006) what is central is the point that both methods emphasise the generation of a theory from the data. As emphasised by Walker & Myrick (2006) the major differences in the method is the data analysis process and procedures used and the

activities of the researcher whilst engaging with the data. In particular, this centred on the main issue of coding. Glaser (1978) described 18 theoretical codes referred to as coding families to assist researchers to analyse the data using the grounded theory method. He further added to these coding families in his texts published in 1998 and 2005 where it was further emphasised that researchers may use one or more of these coding families. The theoretical codes described by Glaser (1978) and commonly known as the Six C's "comprise the conceptual codes of "causes, context, contingencies, consequences, covariances and conditions" (p.74). Strauss and Corbin (1990) outlined the use of a 'paradigm model' which is linked to the 6 C's as their framework for data analysis. It is here that Glaser reports that this method of analysis promoted forcing rather than emergence of the theory (Glaser, 1992).

McCann & Clark (2003) further highlight that the approach used by Glaser emphasises the "socially constructed world of participants" whereas the approach by Strauss and Corbin has a broader approach with consideration to both "the cultural scene and the participants constructed reality" (p. 24). Overall, there is a general consensus amongst the literature that Glaser has remained more faithful to the original form of grounded theory (Heath & Cowley, 2004; McCann & Clark, 2003; Walker & Myrick, 2006).

Another contentious issue identified by the researcher was the use of symbolic interactionism termed as the basic underpinning of the method of grounded theory. When the researcher looked at the original works of both Glaser and Strauss (1978) little is written on symbolic interactionism. According to Glaser (1998, 2005) he argues that symbolic interactionism is not inherent in a grounded theory study. He believes that grounded theory can be used with any theoretical perspective as it is a general inductive model or paradigm. As discussed by Glaser (1992) the grounded theory method took the interpretation of meaning in social interaction on board and studied "the interrelationship between meaning in the perception of the subjects and their actions" (p. 16). Further Glaser (2005) explains that theory generated from the analysis of data with symbolic interactionism reduces the power of the original method of grounded theory by ignoring its roots based on the concept- indicator model (Glaser, 2005; Newman, 2008).

Glaser (2005) asserts that there is a tension between the use of grounded theory and symbolic interactionism as symbolic interactionism is not a foundation of Glaserian grounded theory; "one or several of the coding families can be used in the integration of the theory hypotheses; it imposes a conformity when interpreting concepts and there is no freedom of discovery during the constant comparison method; it closes the researcher to the full range of theoretical codes which can emerge; the researcher when analysing data may only look at the symbolic interactionism perspective, ignoring relevant structural categories and sensitivity as required of the Glaserian grounded theory method" (Glaser, 2005, pp. 155-156).

The different methodology and debates on the use of Glaserian or Straussian grounded theory continue. Since the divergence of the original method another variant, constructivist grounded theory has surfaced as an extension of Strauss & Corbin's original work using the

basic grounded theory guidelines. This method was first proposed by Kathy Charmaz (2000) another American sociologist who believed that the constructivist approach considers both the people and the researchers construction of realities in which they participate (Charmaz, 2006; Mills, Bonner & Francis, 2006). Other researchers have also used grounded theory flexibly with other qualitative applications such as hermeneutics (Annells, 1996; Annells, 1997; Wilson & Hutchinson, 1991) and feminist grounded theory (Wuest & Merritt-Gray, 2001).

For the novice researcher using this type of methodology, the divergence in methods can be quite confusing and difficult to interpret. It is important to note that the researcher undertook reading both divergent methods to gain a solid understanding of the grounded theory research process and procedures. As stated by Heath and Cowley (2004) there is a benefit in researchers familiarising themselves with both the similarities and differences in order to “select the method that best suits their cognitive style” (p. 141).

2.3.3 Researchers rationale for choosing a grounded theory method for this study

The rationale behind the choice of using firstly a qualitative and specifically the grounded theory method towards this study is noted. A qualitative methodology such as the grounded theory method was chosen for this study because it was viewed as the most appropriate methodology, for ontological and epistemological reasons for exploring the phenomenon under study. As noted earlier in this chapter ontology refers to the nature of reality for the participants within a study (Denzin & Lincoln, 2005). Therefore it was important to the researcher that the participants provide their own perspectives and reality to the study area. Furthermore, it was also important to encompass epistemological reasons such as the need for the researcher to expand on new knowledge and also reflect on her own assumptions and what is known about the subject area (Denzin & Lincoln, 2005). The grounded theory method was also chosen to expand knowledge, given the experiences of perioperative nurses participating in multi-organ procurement surgery was a largely unexplored phenomenon which would benefit from the use of experiential data reflecting the participant’s reality of the experience. This method was also best able to meet the objectives of the study as it allowed for the identification of the basic social psychological problem and the basic social psychological process which describes how participants resolve the problem they encountered by working through a process. Therefore, as the main focus of the research study was to discover the main concerns of the perioperative nurses and to explain the psychosocial processes used, the use of grounded theory was considered as the most appropriate method.

Grounded theory is also a suitable research method to use in areas where little or no research has been conducted (Glaser, 1978). As a result, the grounded theory method allowed the discovery and development of a substantive theory generated from the research data to explain the unique viewpoint of perioperative nurses assisting in multi-organ procurement surgery both in New South Wales and Western Australian operating suites. Therefore, the nature of the phenomenon to be studied in addition to the lack of

existing research findings provided a justification for the suitable use of a grounded theory method.

Having read the original text of grounded theory by Glaser and Strauss (1967) the researcher felt compelled to conduct the research study using the original grounded theory method (Glaser & Strauss, 1967; Glaser 1978) which is commonly now referred to as classic or Glaserian grounded theory (Artinian, Giske & Cone, 2009; Glaser, 1992). This original method seemed to be the easiest to grasp, given the researcher was able to refer to the numerous Glaser texts available (Glaser, 1967, 1992, 1994, 1995, 1996, 1998, 2001, 2003, 2005, and 2007) in regards to seeking clarification in the methods and procedural steps.

2.4 Researcher preparation prior to going out into the field

Prior to going out into the field the researcher obtained ethical approval to conduct the research study firstly through the university and secondly by the various hospital research ethics institutional boards. In addition, during this time the researcher also reflected on and qualified why the study area had been chosen. Moreover, the researcher documented her assumptions by undertaking a reflexive review prior to going out into the field and commencing data collection in order to reduce any bias of the data that would be gathered and analysed. These activities undertaken by the researcher are categorised below.

2.4.1 *Gaining ethical approval to conduct the research study*

To undertake the research study the researcher made herself familiar with the Australian National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research (2007b). After preparing the relevant ethics applications the researcher obtained permission to conduct the study firstly from Curtin University's Human Research and Ethics Committee HR 152/2008 (Appendix A). Ethics approvals were also obtained from participating health services Human Research Ethics Committees within Western Australia (See Appendices B to D).

In NSW ethics applications were not made as recruitment of participants took place after the study was advertised via a flyer both nationally in a perioperative nursing journal (ACORN Journal) and a through the NSW state perioperative newsletter (SuiteTalk). As participants were not directly recruited from hospitals and they contacted the researcher independently of their health service, ethics approvals were therefore not required. Although this was the case, the researcher disclosed to the participants that the study was approved by the Curtin University's Human Research Ethics Committee whilst also quoting the approval number on all research correspondence.

2.4.2 *Recognition of researcher's interest in the study area*

As the researcher comes to the study as an experienced perioperative nurse of 17 years coupled with previous experience in organ procurement surgery there was a motivation to explore this substantive area. To achieve the objectives and purpose of the research study,

the broad research question of “What are the experiences of perioperative nurses when participating in multi-organ procurement surgery?” was asked. A broad form of questioning minimises the possibility of restricting the study to a narrow focus so as not to limit the understanding of the relevant concepts (Glaser, 1978, 1992).

Glaser (1998) contends that motivation for researchers considering a grounded theory project in a substantive area bears on a ‘life cycle’ interest which motivates the researcher’s interest and energy in studying an area (Glaser, 1998, p. 48). This was the case, as the researcher had chosen an area of professional interest within a subject which was not only significant to the researcher and the perioperative nursing environment, but was also identified as an area of interest at a national level by organ donation agencies. The perioperative nurse participating in multi-organ procurement surgery within the operating room environment was a relatively unexplored area internationally with limited literature and research results. When compared to the Australia context it was identified that there was a paucity of research within this substantive area. The researcher therefore had an interest within this substantive area as it was pertinent to the specialty area in which she practiced and there was an apparent lack of knowledge, particularly within an Australian context.

2.4.3 Researcher awareness and assumptions

Researchers come to studies with various assumptions and preconceived ideas which can potentially influence the conduct of the study and the interpretations provided by participants (Cutcliffe, 2003; Gearing, 2004). In qualitative research, the researcher is the main instrument in data collection and analysis and therefore there is a risk that researchers could impose forms of bias and subjectivity to how the data is collected, interpreted and presented (Ahern, 1999; Cutcliffe, 2003; Drew, 2004; Gearing, 2004). To alleviate this, qualitative researchers often use bracketing which is a technique where the researcher puts aside their experiences or knowledge. Tufford & Newman (2012) define bracketing as a method “to mitigate the potentially deleterious effects of preconceptions that may taint the research process” (p. 80). Mallory (2001) further explains that researchers with experience on the research topic or population must examine their own values, beliefs and pre-dispositions as these could impact on the research study process itself. Further, she recommends that self evaluation of the researcher’s personal and professional values takes place at the onset of the study to distinguish the researchers and participants differences (Mallory, 2001).

As the researcher had worked in the perioperative specialty area, the researcher came to the study with both experiential and personal knowledge about the phenomena of interest so it was important to be aware of any possible biases prior to commencing the study (Cutcliffe & McKenna, 1999; Hall & Callery, 2001). Although already indicated that a reflexive review and bracketing was undertaken prior to the commencement of the study, the researcher continued to detail the researcher’s own assumptions, personal views and beliefs throughout the study. This was undertaken to ensure that the researcher’s personality, beliefs and knowledge of the subject area were not compromising the research

outcomes. A personal diary was therefore used throughout the data collection and analysis process. Within this diary the researcher's ideas, thoughts and feelings were recorded. The researcher noted the following various assumptions:

1. That participation experiences in procurement surgery were traumatic and viewed negatively by nurses
2. Lack of education and training of perioperative nurse in procurement surgery increased their stress and coping responses during participation
3. More experienced nurses were better equipped to cope with their experiences of participating in multi-organ procurement surgery
4. Younger and less experienced nurses would find participation more difficult
5. As a result of perioperative nurses participating in these procedures they would not donate their own or a family members organs, thereby hampering donation efforts
6. The religious views of perioperative nurses would impact on their participation experience and views on donation

It is important to disclose that the researcher had directly participated in four multi organ procurement surgical procedures in hospitals both in Western Australia and New South Wales within the first five years of perioperative nursing practice. These experiences were in the researcher's earlier years of practice (1995-2000) and included numerous roles such as a scrub, scout and anaesthetic nurse during these procurement surgical procedure experiences. The researcher also acknowledged having no prior professional training or education specific to the organ donation process or the surgical process of organ procurement surgery at the time of her participation experiences. In addition, to the researcher's professional experience in procurement surgery the predominant interest in the study was sparked by a personal experience in 2004, when the researcher after experiencing a motor vehicle accident was asked whether she was an organ donor. This prompted the researcher to question why these procedures had little attention and whether the impact on the researcher was also felt by other perioperative nurses when participating in these surgical procedures. Therefore, according to Glaser (1992, 1998), it is normal for a researcher to have both a personal and professional experience associated with a 'life cycle' area of interest.

2.5 Data collection

To undertake this study, the research setting and data collection was accessed from both New South Wales and Western Australian perioperative nurses with experience in participating in multi-organ procurement surgical procedures. As described by Glaser (1998) "all is data" therefore when undertaking a grounded theory research study sources of data can include the following; interviews, observational field notes, journals, books, videos, written words in magazines or newspapers, photographs, and quantitative surveys (Glaser, 1998, p. 8). To undertake this study the researcher provides an overview of the research setting, sample and recruitment in addition to how data was collected from a combination of six sources; 1) participant demographic data; 2) interviews; 3) the use of memos; 4)

reflective journaling; 5) diagrams and conceptual models and 6) literature and documents. The collection of data was undertaken from July 2009 to March 2010.

2.5.1 Research sample, setting and recruitment

For this study perioperative nurses with experience in participating in multi-organ procurement surgery were recruited. The perioperative nurses participating in the study came from ten different hospital sites across New South Wales and Western Australia. In New South Wales, participants came to the study from rural, regional and tertiary care hospital operating suites. In Western Australia, the participants came from large metropolitan tertiary care hospital operating suites. It is important to note that at the time the research study was conducted, NSW was undertaking multi-organ procurement surgery from both brain dead donor and donation after cardiac death (DCD) donors whereas in Western Australia legislation to initiate and conduct DCD procedures had not been passed until late 2010 after which data collection for this study was completed.

For participants to contribute to the research study they were required to have experience of the phenomenon under investigation. The researcher therefore sought participants within the perioperative nursing specialty with previous participation experiences in multi-organ procurement surgery. Once ethical clearances were obtained from the relevant health services, the researcher made initial contact through formal letters to Nurse Managers (Appendix E) which requested access to present a 15 minute PowerPoint presentation (Appendix F). The presentation outlined the objectives of the study to perioperative nurses at a morning staff education session in order to recruit potential participants. At the conclusion of the presentation the researcher left a laminated printed copy of her PowerPoint presentation, two study advertising flyers (Appendix G), a participant information sheet (Appendix H), a research consent form (Appendix I) and the researcher's contact details in the nurses' tea room. The response rate to this process was favourable and many interested perioperative nurses responded to the requests to participate in the study by getting in touch with the researcher directly. Suitable appointment times were made where the researcher attended the operating suites to meet and conduct interviews.

As noted earlier, to assist with recruiting NSW participants the researcher got in touch with the editor of the ACORN journal to advertise the study via publishing a flyer in the journal. The flyer was published both in the summer 2009 ACORN Journal edition, (Appendix J) and autumn 2010 ACORN Journal edition, (Appendix K). In addition, the researcher also consulted with the local NSW operating room association and requested a flyer go out with their annual newsletter 'Suite Talk' to perioperative nurse members. This flyer was also attached and forwarded to all members in the December edition of 'Suite Talk' 2009 Newsletter (Appendix L). Again the response rate from interested participants was positive with many of the perioperative nurses initiating contact with the researcher directly from the advertised flyers.

Once participants from NSW contacted the researcher, the researcher forwarded interested participants' a '*NSW Perioperative Nurse Research Information Pack*' which included the following items; a covering letter (Appendix M), which included the research information sheet (Appendix H), a demographic profile questionnaire (Appendix N), a research consent form (Appendix I) and the researcher's contact details. Interested nurses contacted the researcher to schedule an appointment with the researcher. A trip to various NSW locations to meet and conduct interviews was undertaken in early March of 2010. This trip included regional, rural and metropolitan NSW sites to meet with the perioperative nurses to conduct interviews. Due to travel restrictions and logistics these interviews were conducted at the most convenient and suitable sites as was determined by the participants.

2.5.2 Research participant inclusion criteria and selection of participants

Participants who met the following inclusion criteria were included in the study if they:

1. Were a Registered or Enrolled perioperative nurse who was or had recently worked in the operating suite, in Western Australia or New South Wales
2. Were a perioperative nurse who had participated in multi-organ procurement procedures and has fulfilled one or more of the following roles in the operating suite; a scrub nurse, scout nurse or anaesthetic nurse
3. Had participated in at least one multi-organ procurement surgical procedure
4. Provided written consent to participate in the research study

Participants who met the inclusion criteria were selected to the study based on meeting the above inclusion criteria using both purposive and theoretical sampling techniques. This was to ensure that the theory had a rich and dense description of the events and incidents that influenced the perioperative nurses experiences of the phenomenon under investigation (Morse & Richards, 2002; Sandelowski, 1999; Streubert Speziale & Carpenter, 2003). Initially purposeful sampling techniques were employed to interview perioperative nurses with exposure and experience of working in multi-organ procurement surgical teams as these nurses could reflect and articulate their experiences to the researcher. As data was analysed simultaneously against subsequent interviews various categories began to emerge, which were further explored in subsequent interviews by the researcher employing theoretical sampling techniques and the recruitment of further interview participants.

Theoretical sampling is defined as "the process of data collection whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser & Strauss, 1967, p. 45). Gradually, the interview process was guided by the process of theoretical sampling to include participants with slightly different backgrounds or experiences to those identified during purposeful sampling. For example, this process guided the inclusion of perioperative nurse participants with less professional experience in the operating room specialty; perioperative nurses with transplantation exposure and participation; perioperative nurses with DCD experience and the experiences of anaesthetic nurses involved in multi-organ procurement surgical procedures. These participants were invited on the basis of how their

experiences added to the understanding of the phenomenon under study. As described by Glaser (2005) theoretical sampling chooses comparison groups with different perspectives to increase the conceptual level and scope of the theory. As Glaser and Strauss (1967) maintain when using theoretical sampling, the researcher questions “What group or subgroups does one turn to next in data collection and what type of questions to ask” (p. 47). Theoretical sampling therefore contributed to further exploring the social context of the experiences of perioperative nurses participating in multi-organ procurement surgery to determine whether other nurses had similar experiences or views. These similarities and differences were further verified by subsequent interviewed participants to shed light and clarify emerging categories and the developed theory. Theoretical sampling continued until theoretical saturation was reached. Theoretical saturation occurred when no new information or insights were being collected from the participants and where categories were expansive and complete (Charmaz, 2006; Chenitz & Swanson, 1986; Glaser & Strauss, 1967). Therefore selection of participants and a final sample size was determined by the process of theoretical saturation.

2.5.3 Ethical considerations

The researcher ensured that the proposed study adhered to the National Health and Medical Research Council (NHMRC) Statement on Ethical Conduct in Human Research (2007b). It was the researcher’s responsibility to protect participants during the research study by paying particular attention to minimising the risks of harm and discomfort (Orb, Eisenhauer & Wynaden, 2000). The researcher identified that there was a small risk of participants potentially experiencing upset or distress at revisiting a previous traumatic experience related to organ procurement surgery. In preparation for this occurrence, the researcher ensured that when participants seemed upset or distressed that the interview was paused until the participant was ready to recommence. During the interviews a few of the perioperative nurses did become visibly upset at recounting some of their experiences. At this time participants were asked how they would like to proceed gently, whether they wished to continue with the interview or whether they would like to withdraw from the interview process. All of the participants choose to continue with their interviews. These perioperative nurses later expressed gratitude at having an opportunity to talk to someone for the first time about their experiences. To ensure that participants were protected from harm, the researcher had put in place measures for professional counselling support to be available at the selected hospital sites prior to commencing interviews with participants. This ensured that participants would be cared for professionally if required. The researcher also informed participants that she was available should participants want to further discuss or talk about any issues they may have encountered as a result of the interview process. No participants sought or required counselling or contacted the researcher to discuss any further concerns any issues following the interview process.

Another ethical consideration addressed by the researcher was the confidentiality of all participants. Prior to being interviewed participants, were asked to read the information sheet (Appendix H) which outlined the purpose of the study and detailed their rights of confidentiality. The researcher also discussed this with participants prior to them

proceeding to sign the consent form (Appendix I) to participate in the study. To ensure that participants were not identifiable or their identity was compromised the researcher allocated a numerical coding system of all information supplied by the participants (e.g. audio taped interviews, interview transcript, demographic profile). Therefore, each participant's identity of their recorded interview was assigned a numerical code number based on the date and time of the interview. A log book was kept by the researcher in a separate location which matched the allocated numerical number to each participant's identity with another document which contained all the participants contact details. Both of these documents were kept in the researcher's home filing cabinet which was locked and only accessible by the researcher. In addition, the management of the interview data through the use of the NUD.IST software package was also protected via a password. Furthermore, confidentiality of both participants and Hospitals involved in the study has also been assured when citing findings within the thesis, in publications and conference presentations. All data gathered such as audio taped interviews, interview transcripts, memos and log book used for the duration of the study has been kept in a secure locked location by the researcher and will be kept in its original form for a period of 5 years and will then be destroyed.

2.5.4 Obtaining participant's consent

At the time participants had agreed to take part in the research study, the researcher introduced herself and again verbally outlined the purpose of the research study, in addition to providing participants again with an information sheet (see Figure 2.1).

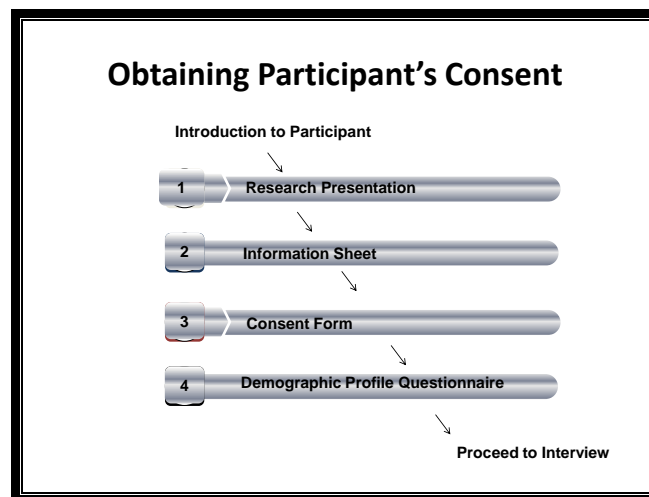


Figure 2.1: Obtaining participant's consent to participate in the study

Participants were informed that the interview process would take approximately 60 minute duration and would be audio taped. Participants were also reminded that they could stop the interview at any point if they required and withdraw from the interview without providing any reason. Participants were also further advised that a follow up interview may be needed to clarify information collected during the first interview and that this would be arranged according to their availability and permission. It was noted that perioperative

nurses from NSW wanted further information on the purposes of the research study and the researcher brought with her a laptop computer to present the same 15 minute PowerPoint presentation individually to each participant when she met with them for the first time. She answered any of their questions at this time which also provided an opportunity to gain mutual understanding and trust between the participant and the researcher. When participants were satisfied that their questions had been answered, they understood fully what was required of their participation, and they were ensured of their confidentiality, a formal written consent form was completed prior to collecting any data.

2.5.5 Research participant's demographic data

This study attracted thirty seven perioperative nurses to voluntarily make contact with the researcher and express an interest in participating. Thirty five perioperative nurses participated in this research study before theoretical saturation was achieved. The participants consisted of 33 females and two male perioperative nurses. Each participant was also asked to complete a demographic profile questionnaire (Appendix N) which collected details such as the nurses' gender, age, country of birth, religion, employment history, education and experience in procurement.

Data gathered from the demographic profile questionnaire has been presented here to give the reader a detailed overview of the participant's profiles who informed the study. The researcher felt it was important to distinguish the participant's profiles by each state to complete a full picture to the reader of the scope and levels of experience, age and education of the participants who informed the study. The ages of the perioperative nurse participants at the time of data collection ranged from 27 years to 64 years of age as illustrated in Figure 2.2. The majority of perioperative nurse participants were between 40 and 60.

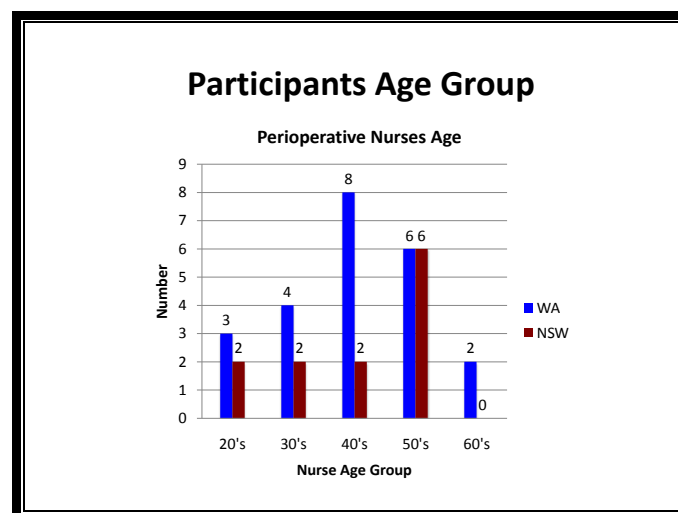


Figure 2.2: Participant's by age group

As illustrated in Figure 2.3 all the participants were experienced perioperative nurses, with varying clinical roles such as; enrolled nurse (EN); registered nurse (RN); clinical Nurse (CN); staff development nurse (SDN) and clinical nurse specialist (CNS). It must also be noted that

in NSW the nursing career structure is different in that the CNS role is equivalent to the WA role of a Clinical Nurse (CN). So as not to confuse readers, the state specific role designation is used.

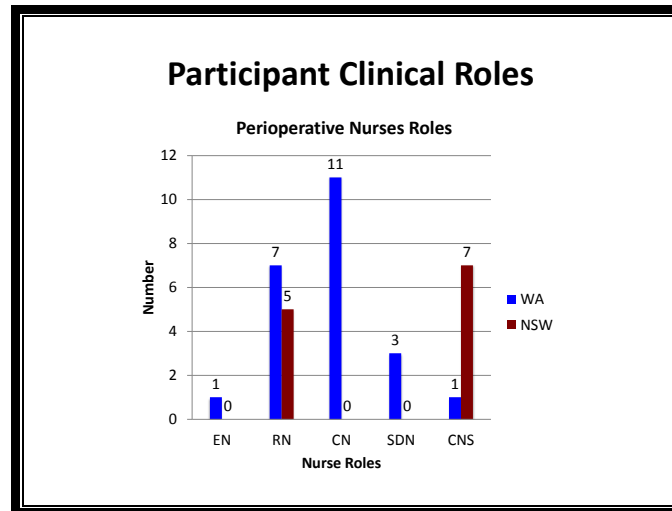


Figure 2.3: Participant's clinical roles

Years of professional nursing experience within the perioperative area ranged from 3 to 39 years. Participants held varying levels of nursing qualifications and education as indicated in Figure 2.4; 14 nurses were hospital trained with a hospital based certificate and 21 had completed nursing qualification at a tertiary level. The data also revealed that 12 nurses also held postgraduate qualifications either within the perioperative environment or another nursing postgraduate specialisation.

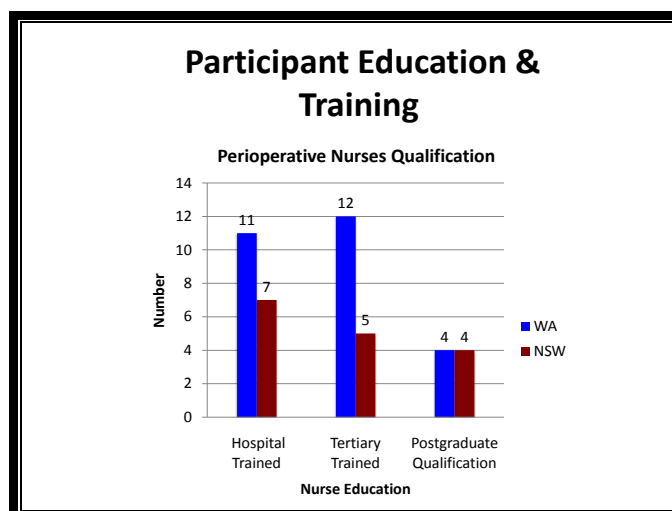


Figure 2.4: Participant's education and training

As a group these perioperative nurses had undertaken and been involved in 314 multi-organ procurement surgical cases from both NSW and WA. A breakdown of participation by the perioperative nurses per state is provided in Figure 2.5. Of the 12 participants from NSW the nurses reported participating in 96 multi-organ procurement cases. In WA, the participants reported undertaken 218 multi-organ procurement cases.

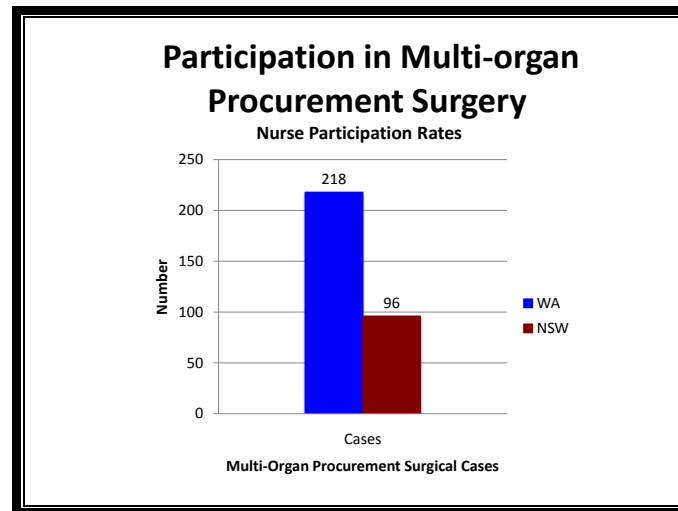


Figure 2.5: Nurse participation rates in multi-organ procurement surgery by state

As a combined group Figure 2.6 provides the reported sources of education provided to the perioperative nurse participants towards undertaking their roles in multi-organ procurement surgical cases. One participant reported being provided with some information about organ donation at a perioperative course overview. Two perioperative nurses were provided with information whilst attending a Hospital In-service. Six participants reported education on procurement being provided by on the job training at the time of participation. Twenty six of the participants were not provided with any form of education.

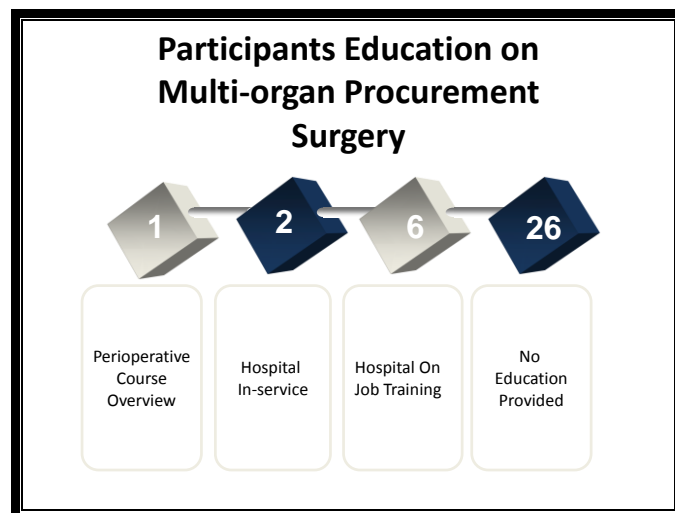


Figure 2.6: Modes of education on procurement surgery

A further breakdown of the modes of education for multi-organ procurement surgery is provided for both NSW and WA Figure 2.7. The researcher felt it important to ascertain which state provided more education to nurses on procurement surgery. What the researcher noted was that the majority of participants from both states had not had any forms of formal education in organ procurement surgery.

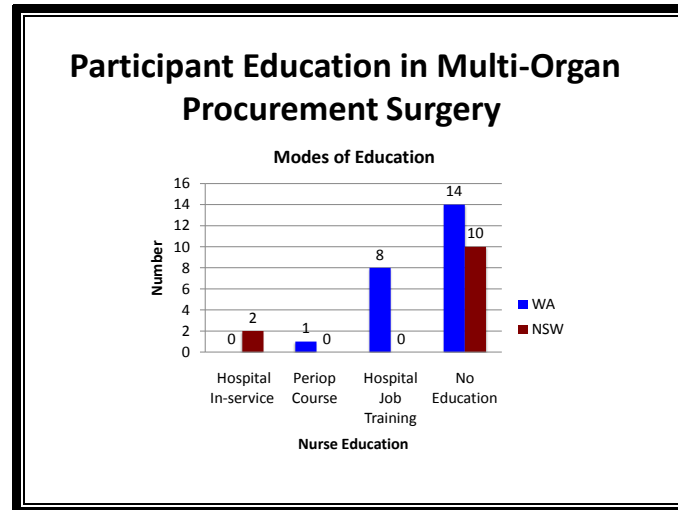


Figure 2.7: Modes of education by state

Moreover, participants were also asked whether they had received any forms of support after participating in multi-organ procurement surgery. As illustrated in Figure 2.8, of the 35 participants, 25 reported not receiving any forms of support post procedure. Six of the participants were asked verbally if they were okay and two participants reported being provided with counselling. One participant was supported by the Donor Coordinator and one other participant did not disclose whether support was provided and this participant reported only that they did not seek any forms of support. Therefore this participant could not be placed in one of the other categories.

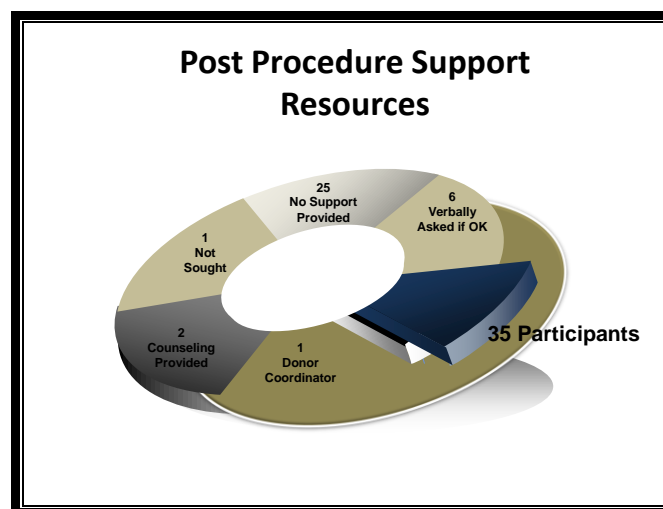


Figure 2.8: Post procedure support resources

The participants were also asked their religious affiliations and they reported coming from varied backgrounds of religious faiths which included; Anglican, Presbyterian, Catholic, Muslim, Buddhist and Pagan.

Although not reported in the demographic data, participants were asked during the interview process whether they would donate their own organs as a result of participating in multi-organ procurement surgical procedures. The researcher decided to include this data under this section for ease of reference for the reader and to keep statistical data organised. The researcher has also broken down these responses by each state. As noted in Figure 2.9, the majority, (23/35) of the perioperative nurses indicated intentions to become organ donors themselves. Five of the perioperative participants reported that they would not be an organ donor whereas a further seven were undecided.

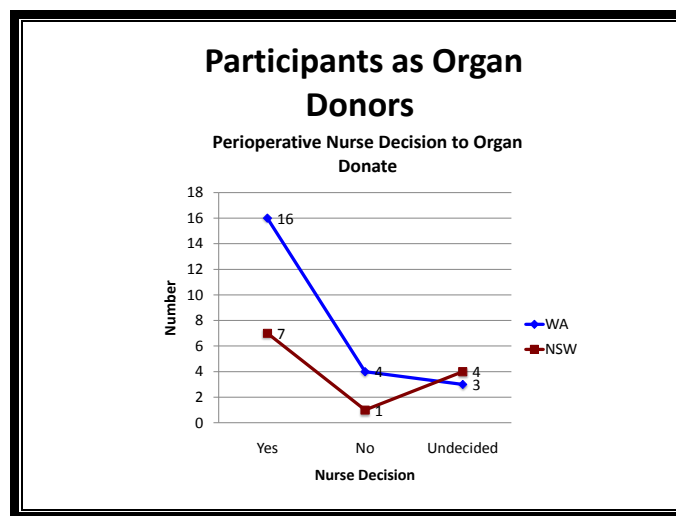


Figure 2.9: Nurse's decision to organ donate

2.5.6 Research interviews

The major data collection method to inform this study was the use of semi-structured interviews which commenced in July 2009 and extended to April 2010. Thirty five interviews were undertaken ranging in length from 30 minutes to 130 minutes with an average interview time lasting 60 minutes. In total 33 hours of recorded interviews were undertaken. Each participant was interviewed separately at a mutually agreed venue, time and place. Many chose to be interviewed at their place of work.

The operating room environment is known to be a busy and noisy environment, with machinery and equipment, patient monitoring, speaker announced emergency systems, emergency alarms and pagers contributing to background noise. At times although every effort was made to select a quiet room or area to conduct interviews, this was not always possible and interviews had to be conducted close to the operating room environment for participants whilst also on duty should an emergency procedure take place. Therefore locations of interviews varied considerably at the various hospital sites using whatever offices or seminar rooms were available. Four of the participants from New South Wales

agreed to be interviewed at the researcher's hotel for convenience. One of the New South Wales participants had an interview over the phone. For the majority of the perioperative nurse participants, the managers at the respective sites facilitated interviews to take place during work hours and made available time for interested participants to participate in the interview process with the researcher, whilst the other participants either came to work earlier prior to their shift start or stayed back to meet with the researcher in their own time.

The interviews were semi-structured and open-ended to obtain rich experiential data from the perioperative nurses participating in multi-organ procurement surgery. As described by Minichiello, Aroni, Timewell and Alexsander (2000) semi-structured interviews focus on the issues that are central to the research question thereby allowing a greater flexibility in the questioning and the discussion of the topic area. The content of the interviews were therefore guided by the objectives of the research study (Glaser, 1998; Minichiello et al., 2000; Morse & Richards, 2002). An interview guide was utilised by the researcher which outlined the semi-structured open ended interview questions as presented in (Appendix O). As reported by Minichiello et al. (2000) the interview guide does not necessarily determine the order of the conversation or questioning (p. 82). During the interview process there was no order in asking of the questions which were linked to the topics that the researcher was interested in covering. The researcher commenced by asking the participants open-ended questions such as "How long have you worked in the operating room?" and "Can you tell me about your experiences participating in multi organ procurements surgery?" With the use of theoretical sampling techniques each subsequent interview questions became more focused to ensure that the objectives of the study were met.

The researcher took into consideration various elements to engage positively with the interview participants such as language skills and non-verbal communication. As explained by Minichiello et al. (2000) establishing rapport is essential as the participant will be more communicative during the interview. Therefore, it was important for the researcher to initiate appropriate interpersonal interview skills as this was essential in establishing rapport with each participant (Rossman & Rallis, 1998). The researcher established rapport by being neutral; showing interest in what the participant had to say; engaged with the participant in a positive manner to make them feel as comfortable as possible. If there were any responses that surprised the researcher she ensured that she adapted to these situations by remaining neutral to the information provided so as not to influence the participants' responses. In anticipation of these circumstances where participants were divulging graphic or deeply personal accounts during the interview process, the researcher ensured she had adequately prepared her interview technique by bracketing her own experiences and knowledge prior to each interview so as the researchers views on the topic continued to remain neutral.

During the interview process the researcher took notes and jotted down new concepts that had been mentioned to remind the researcher to obtain further information or elaboration by the participant. Minichello et al. (2000) emphasises that there is a risk of less rapport and natural contact with the participant if the researcher is taking notes. However, at the

same time they also report the benefits in taking notes as this assists the researcher to analyse and make earlier interpretations of the data and the opportunity to record body language and speech patterns (Minichello et al., 2000). For the researcher note taking was employed so as not to cause disruption to the flow of the interview by prompting the researcher to follow up on certain questions at an appropriate time later in the interview. In addition this aided the participants to feel a little more comfortable as the researcher was not directly having constant eye contact for the full interview process. In addition the researcher also referred to the interview guide or her jotted notes as a future reference to further clarifying a topic.

At the conclusion of the interview a few of the nurses thanked the researcher for undertaking and emphasising the importance of this research for perioperative nurses and also expressed gratitude that they had finally had an opportunity to voice and talk about some of the issues which they had encountered as a result of their participation in these surgical procedures. For some participants these interviews were used as an opportunity to voice their experiences, doubts and thoughts to somebody else for the first time. Further, the researcher also provided each participant with a thank you letter at the conclusion of each interview should they like to make further contact (Appendix P).

2.5.7 Memos

Memos as described by Glaser (1998) are the written form of the researcher's abstract thinking. Glaser (1998) suggests constantly stopping and getting ideas down in writing so as vital ideas are not forgotten. Glaser (1978) explains four basic goals in memoing; to theoretically develop ideas, to develop ideas freely, to provide memos that are highly sortable and, to develop a memo fund. Memos were recorded at the completion of each interview. Each memo was recorded in a memo log book to ensure that no memos were lost. The process of memoing also included the researcher documenting all descriptions, explanations and justification of decisions related to data collection and theory development. This served as an audit trail of the researcher's thoughts, contained information about the participant's body gestures or any visual cues and a record of further lines of inquiry (Cutcliffe & McKenna, 1999; Saldana, 2009). Memoing was vital during the analysis process of identifying theoretical concepts and ideas which were drawn from the data under investigation. According to Glaser (1998) "memoing captures and keeps track of the emerging theory" (Glaser, 1998, p. 177). Therefore, memoing is integral in the theorising and write up stage as without memoing the theory can be described as superficial and the concepts generated as not original. The following is an example of a memo undertaken by the researcher after undertaking three interviews in the same day:

Today's interviews were exhausting. I got the feeling, perioperative nurses were reluctant to talk about their emotions as they spoke of the need to hide their emotions. Sometimes their descriptions of the procedure were graphic, cold and abrasive. When speaking of the donor, the participants were distant as if they lacked emotion. I would like to explore why? I had interviewed both a young nurse and an older nurse with differing experience levels and felt that both participants wanted to express to me

that they were coping when participating in these procedures however as the interviews progressed they were saying the opposite. It's as if they hide behind a tough exterior and were very clinical in their descriptions. I wonder whether this is part of the OR culture or the way perioperative nurses must function in order to undertake traumatic aspects of their work. The older nurse was more experienced however similar patterns of behaviour and interview responses were given as the participants responses clearly emphasised struggling to cope internally. Hiding seems to be a predominant theme discussed in the interviews and is becoming a main concern for the majority of participants. I would like to explore and compare these experiences with other nurses who are exposed to procurement surgical procedures and why is it necessary to hide emotional reactions to these participation experiences. (Memo 4, 16/7/2009 @ 1245pm).

2.5.8 Reflective journaling

To further reduce researcher bias and assist with bracketing, the researchers kept a reflective journal to write about some of her concerns, thoughts and thinking. At times, throughout the research process the researcher felt the study was quite confronting when her own personal views were challenged. An example of this was when the assumptions the researcher held were not supported by the data as the participants provided different perspectives. This was interesting for the researcher as it confirmed Glaser's statement that researchers could not impose bias as the grounded theory method itself provided safeguards such as the use of the constant comparative method of analysis, identification of the core category and the findings which are grounded in the data gathered by the participants explaining their main concern (Glaser, 1992). Moreover, as Glaser (1998) states "In grounded theory, the product speaks for itself, if the work is well done" (1998, p. 131).

Throughout the research process, as Glaser (1992, 1998) has suggested it is important for the researchers own experiences and thoughts to not be disclosed to participants. The researcher was therefore mindful and very careful not to impose her own experiences or thoughts or force data by keeping an open mind to the emergence of the participant's problems throughout the research process. An example of this occurring was when the majority of the research participants asked the researcher prior to commencing the interviews whether she had in fact participated in a procurement surgical procedure and whether she could talk about her experiences. The researcher responded that she had participated in these surgical procedures however she would share her own experiences if they'd like at the end of the interview to ensure that she was not influencing the interview process in any way. In many ways this reassured participants as they felt more comfortable to share their own experiences as they believed the researcher would have some insight into their experiences. For many who participated in this study, this was the first opportunity to express sensitive and sometimes painful recollections of their experiences in a safe and trusting environment. For others it was an opportunity to share their experiences and how they overcame any issues encountered as part of their professional role.

The following is an example of a journal entry undertaken by the researcher:

My own experiences as a perioperative nurse involved in procurement surgery are quite similar to those already expressed by the participants. I am questioning my views on procurement surgery more and more. How would I feel if one of my children required an organ? Could I give permission for a loved one to donate their organs? I don't want to think of making such a decision. Participants highlight the struggles they faced when thinking about donating their organs, some were against but the majority of nurses expressed a willingness to donate. I too also noted that perioperative nurses continued to not talk about their participation experiences in these procedures. Was avoidance of discussion a way of coping with multi-organ procurement? (Journal entry, 23/12/2009 @1815).

Similarly, another journal entry made the following year:

I am struggling hearing some of the traumatic stories and loss of life of particular donors and the effects on the study participants. I have to distance myself from the trauma of the participant's experiences and focus on the problem and what is happening in the context of the research study. This is difficult sometimes, for example today I was quite moved by one participant who seemed really emotional when talking about her experience in a particular procurement procedure and caring for a young child donor. This experience had stayed with her for many years and this was the first opportunity to share her experience. It was a privilege to hear her story and reinforced the importance of the study and confirmed in my mind the problem of hiding behind a mask becoming more evident within the data. (Journal entry, 3/3/2010 @ 2130)

2.5.9 Diagrams and conceptual models

Conceptual models and diagrams are used in grounded theory to convey concepts of categories and their relationships in a visual format (Charmaz, 2006). Conceptual Models or diagrams can be used to represent themes, processes and concepts or behaviours (Glaser, 1978; Strauss & Corbin, 1990). Various types of diagrams can be used from maps to charts and figures (Strauss & Corbin, 1990). The researcher found the use of diagramming helpful for organising ideas and relationships in a visual format. The researcher initially sketched some diagrams and maps in the early stages of data analysis. Figure 2.10 is an example of a conceptual model made by the researcher.

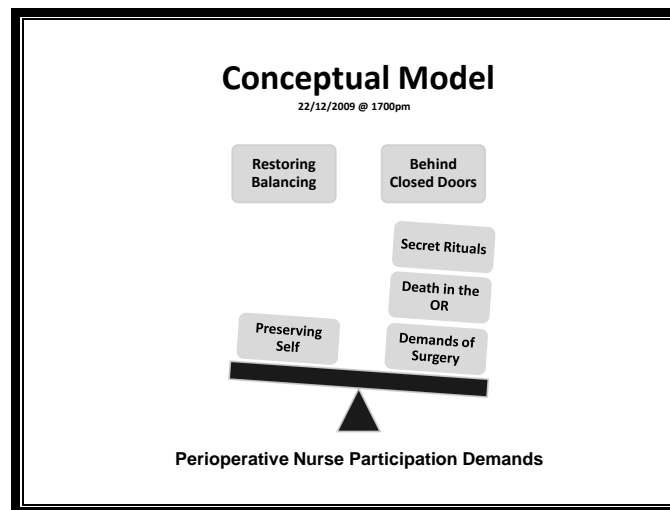


Figure 2.10: Conceptual model

2.5.10 Literature and documents

The dicta of grounded theory proposed that no pre literature review is conducted in the substantive field. This as Glaser (1998) states ensures that the researcher is free and open to the discovery of the emergence of concepts, problems and interpretations clearly from the data itself (p. 67). In addition, it also ensures that the researcher does not obtain any preconceived ideas from earlier studies within the literature (Charmaz, 2006; Glaser, 1998; McCallin, 2003).

Despite this grounded theory dicta, the researcher was required to undertake an initial literature review to meet formal university guidelines towards the writing of the research proposal (McCallin, 2003). As previously noted within this thesis, the pre literature review undertaken at this stage by the researcher identified that there was no current up to date and limited literature on the proposed study topic. The literature review however helped to verify the study's need, purpose and significance. This information also contributed to the development of the research question and identified a gap in research related to the perioperative nurses' experiences of participating in multi-organ procurement surgery. As there was limited literature available in the substantive area the researcher felt that there was no influence from previous research findings therefore predisposing the researcher to any preconceptions.

Glaser (1978) has explained that the use of literature review should be conducted after collecting the data where the literature can be woven into the theory as more data for constant comparison to compare and complete analysis of the research phenomenon (Glaser, 1998; Glaser, 1992). As the researcher conducted data analysis and the theory began to emerge relevant literature was sought as a source of comparison and analysis during theory development. Utilising the constant comparative method various literature was accessed, this included relevant research studies, scientific articles and books to validate findings and to add to the data. This information was used as a valuable source of

comparison and analysis during theoretical saturation to firstly verify the findings and further to place the developed theory in the context of existing knowledge in the substantive area.

2.6 Recording and transcribing of interviews

Interviews were audiotape recorded after receiving appropriate consent from each participant. Recording interviews in grounded theory is a contentious issue as Glaser instructs 'DO NOT TAPE INTERVIEWS' (Glaser, 1998, p. 107). Moreover Glaser (1998) states that "when doing grounded theory there is no need for complete recordings of the interview as one would want in descriptive completeness" (p. 107). However, as the researcher was new to the grounded theory methodological procedures, it was felt necessary to have a back up of each interview to ensure no major data was lost and an audit trail existed.

The researcher sought on two separate occasions, two professional transcribers to assist with the transcription of the recorded participant interviews. Prior to obtaining any interview transcripts both transcribers were issued with a confidentiality agreement to sign prior to forwarding any tapes as noted in (Appendix Q). On receiving the signed confidentiality agreements the tapes were forwarded via registered post. To ensure that the interviews were not lost in the mail the researcher also had made a backup digital copy on her computer in a secure file. As the researcher, had undertaken notes of each interview herself and had made an audio backup copy of each interview she was able to listen to each interview whilst awaiting for the return of the completed transcripts. This in itself allowed the researcher to become more familiar with the data. The researcher further ensured the reliability of the interview transcripts by checking all returned transcripts by relistening to the audiotapes against each participant's transcript where she was able to fill in any missing omissions of verbatim including pauses and inflections by the interview participants.

2.7 Data preparation and computer management

The use of the N Vivo computer software package has been reported as a useful tool to support the qualitative researcher in managing data, ideas, recording, sorting, matching and the linking of data (Bazeley, 2007). The program further provides the researcher with a range of tools to explore connections between various segments of the data and to store textual data for easy retrieval (Morse & Richards, 2002; Stynes, 1995). The researcher initially commenced using the N Vivo 8 software package during the analysis process and to assist with textual data management and storage. However she experienced difficulty in coding the data and handling the overall view of the data. To alleviate this problem the researcher undertook analysis of the data manually which entailed manually coding and highlighting codes and categories on each interview transcript. Manually coding actually benefited the researcher during the analysis process as it brought the researcher closer to the data and reinforced the analytic steps taken. Later the program was used to input and store the textual data for easy retrieval. Therefore for this research study the N Vivo 8 program was only used for the storage of data and codes after manual analysis of the data took place. This did take time to re-enter the data into the program however was useful in

the writing up stage when data was easily retrievable for the purposes of providing thick descriptions from the participants interviews transcripts.

2.8 Data analysis procedures

Data collected for this study was analysed using the constant comparative method of analysis (Glaser & Strauss, 1967). The analysis of data took place simultaneously and against each other by analysing the interview transcripts, literature, demographic profile questionnaire, memos and personal diary (See Figure 2.11). The transcribed data, together with the researchers' memoing, was analysed and organised into codes and categories. Glaser (1998) describes the procedure of coding as assigning categories to incidents in the data such as a phrase or a sentence from an interview. This process lifts the data from an empirical or descriptive level to a conceptual level. Coding and category development involved a two step process of substantive coding and theoretical coding.

2.8.1 The constant comparative analysis

The use of the constant comparative method of analysis is the hallmark of the grounded theory method; a process which is not a linear task for the researcher. It requires the researcher to simultaneously move forwards and backwards between data collection, analysis and theory generation with the use of the fundamental technique of the constant comparative method of analysis (Glaser & Strauss, 1967). Glaser and Strauss (1967) state that, "The purpose of the constant comparative method of joint coding and analysis is to generate theory more systematically ... by using explicit coding and analytic procedures" (Glaser & Strauss, 1967, p. 102). This ensures the generation of categories and their properties from the data gathered and allows the findings to be verified throughout each stage of the analysis process to ensure the findings are accurate and grounded in the data. Glaser and Strauss (1967) describe four main research stages of the constant comparative method; comparing incidents applicable to each category; integrating categories and their properties; delimiting the theory and; writing the theory (Glaser & Strauss, 1967, p. 105).

The first stage of the constant comparative method of analysis took place during open coding of the interview transcripts. At this stage the researcher compared each incident with other incidents applicable to each category. Glaser and Strauss (1967) explain that this stage leads the researcher to recognise "the full range of types or continua of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other properties" (p. 106).

The second stage as described by Glaser and Strauss (1967) integrates the categories and their properties in as many different ways (Glaser & Strauss, 1967, p. 109). This stage also allowed the researcher to identify gaps in the data findings and further collect additional data to integrate. The third stage followed with the researcher delimiting the findings. This was done by refining and reducing the number of categories and their properties into higher level concepts, resulting in parsimony of variables (Glaser & Strauss, 1967, p. 111). The fourth and final stage allowed the researcher to confirm the theoretical findings and the writing of the theory.

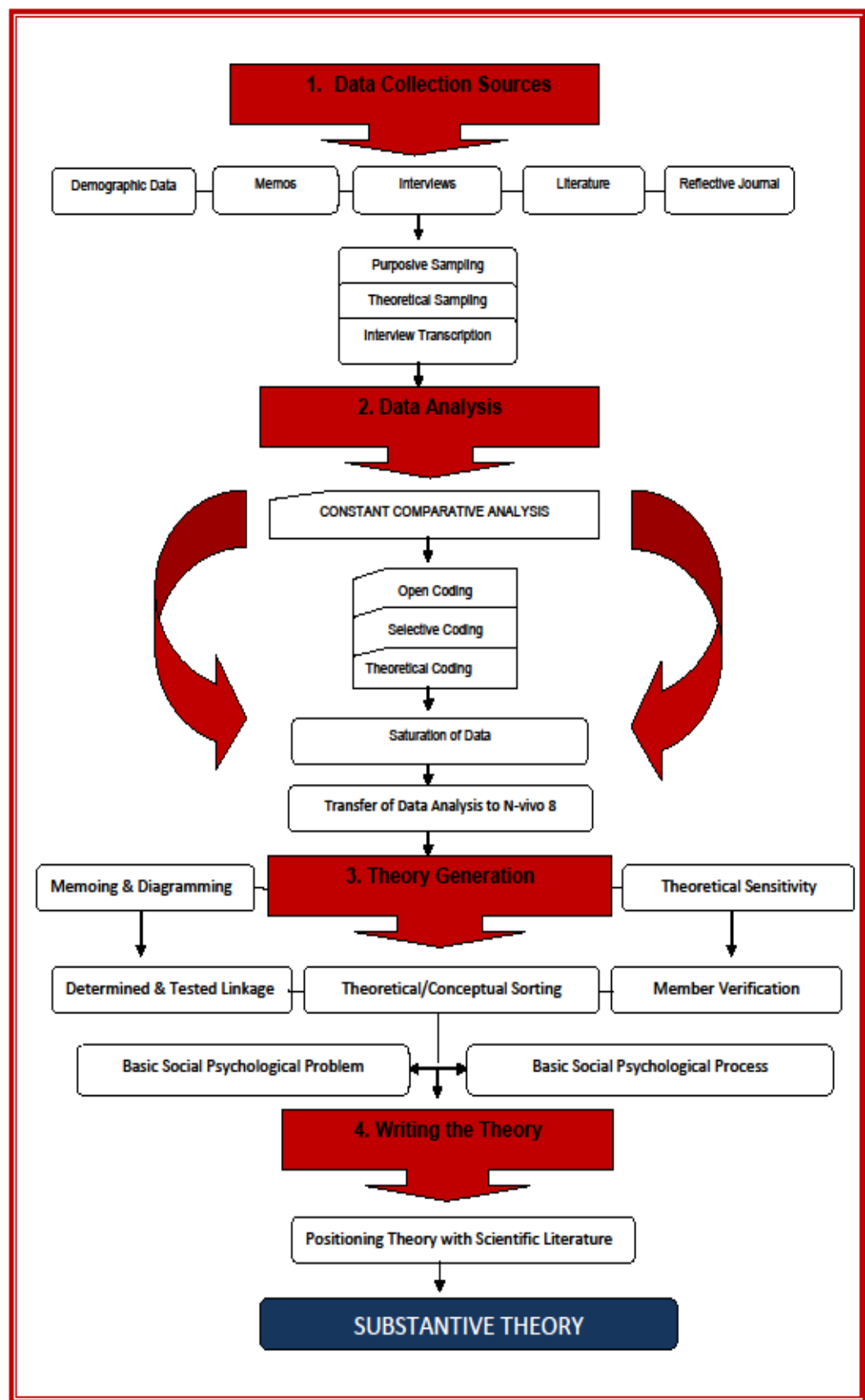


Figure 2.11: The grounded theory research process

2.8.2 The grounded theory coding techniques

The grounded theory method employs two levels of coding. Coding is carried out in two steps: substantive coding which encompasses open and selective coding and theoretical coding.

2.8.2.1 Substantive coding: Open and selective coding

As noted, substantive coding is divided into open and selective coding. The first phase of analysis is open coding which is defined as “running the data open” (Glaser, 1978, p. 56). This process was the initial step in the analysis of the data that lead to the discovery of categories and their properties (Glaser, 1992). The data gathered from interviews, field notes and memos was examined line by line, sentence by sentence to identify common codes, processes or abstract concepts within the data. In many cases the open codes used the participant’s exact words and are referred to as “in vivo codes” (Charmaz, 2006; Glaser & Strauss, 1967; Holton, 2010; Punch, 2005; Streubert Speziale & Carpenter, 2003). Code words were written on each transcribed interview. The open coding method breaks down the data into codes representing meanings of phenomena. These meanings were then compared and contrasted for similarities and differences in other parts of the interview and with interviews conducted with other participants. The process of open coding produced in surplus of 200 codes. These codes were modified, discarded or subsumed under broader code words to better enhance the meanings of the data.

According to Glaser (1992), this stage of data analysis should be used to identify the category or property of a category to which the data being analysed belongs. Data are broken down into phenomena and these phenomena are closely examined for differences and similarities. The researcher also asked neutral questions of the data such as “What is this data a study of?”, “What is actually happening in the data” (Glaser, 1992, p. 51). Use of the constant comparative method allows the researcher to undertake comparisons of phenomena to phenomena, phenomena to concept and the formulation of categories and their properties (Glaser, 1992). In addition, the constant comparative method aids to generate neutral questions to ask of the data, to determine what this data is a study of, and indicate what this phenomenon means to the theory being constructed (Glaser, 1992). Furthermore, this process may also highlight the need for the expansion of the theoretical sample to further clarify, define or consolidate categories and properties identified through open coding.

Selective coding was the next stage of data analysis and was guided by the identification of the core variable. While the process of open coding splits the data into concepts and categories, selective coding allowed the researcher to filter and code data which were deemed more relevant to the emerging core variable. The identification of the core category was central and accounted for variation of behaviours from the participants and it occurred frequently in the data. As described by Glaser (2001) “it is the prime mover of behaviour” (p. 49). According to Glaser (1992) “after sufficient coding and analysis the core emerges; it just has to, as it is on all the participants’ minds one way or another” (Glaser, 1992, p. 77).

At this stage the researcher selectively sampled further and collected new data with the core variable in mind by using the theoretical sampling technique, a deductive part of grounded theory. This step in the analysis delimits the core variables to a basic social process or condition (Glaser, 1978). During selective coding data was compared with additional data and merged into new concepts, renamed and modified. At the same time during this period the researcher wrote memos about conceptual and theoretical ideas which emerged throughout the analysis (Walker & Myrick, 2006). This required the researchers to go over old field notes or memos which were already coded at an earlier stage. Whilst focusing on the core variable the researcher modified and reformulated her interview questions to encompass a more focused direction of the research. Theoretical sampling and data analysis continued until saturation of the categories was complete. According to Glaser & Strauss (1967) saturation is complete when the grounded theory is conceptually complete with no gaps in the data. Therefore the point of saturation was reached when no new insights were obtained from participants (Glaser & Strauss, 1967).

2.8.2.2 Theoretical coding

The process of theoretical coding conceptualises and examines how the substantive codes of open and selective coding relate to each other as hypotheses to be integrated into a theory by “weaving the fractured story back together” (Glaser, 1978, p.72). The core category as described by Glaser (1978) “integrates the theoretical findings” and is described as the “main concern” of participants (Glaser, 1978, p. 93). The core category forms the main storyline as substantiated by the data. The core category emerges from the data as accounting for most of the variations in the data where its properties and relationships to other categories can be verified. Validation of the development of the core category is continually carried out by reviewing the data through further exploration of concepts with subsequent participants. Therefore participants involved in the final stages of the data collection assist to verify the emerging core category. The core category was further integrated to identify the relationship with the core category and core process which facilitated the development of the substantive theory.

The researcher further examined and identified categories related to the conditions and consequences. Theoretical coding families were used by the researcher to assist in making connections or linking patterns amongst the categories of the theory. Glaser (1978) referred to the 18 coding families as a shopping list of theoretical codes to assist the researcher in analysing and thinking about the relationships amongst the categories identified (pp. 74-78). These families of theoretical codes were used to direct and assist the researcher in asking specific types of questions of the data during analysis (Glaser, 1978, p. 74). During the theoretical coding process further data was gathered by theoretical sampling to address any unanswered questions and to verify the evolving theory from further participants. This process further elevated categories to an abstract level and integrated the relationships between these categories. The process of theoretical coding is complete when data is complete and all the categories are subsumed into the core category (Glaser & Strauss, 1967; Glaser, 1992).

The major category identified as representing the basic social psychological problem experienced by the majority of participants and the emergence of the basic social psychological process which details how participants managed and encountered the basic social problem in this study made up the substantive theory. The final analysis of data concludes with the integration of relevant existing theories in the scientific literature for comparison with the study findings and the substantive theory.

2.8.3 *Writing the grounded theory*

The final stage of the grounded theory methodology is the write up of the conceptualisation and integration of the generated theory (Glaser, 1992, p. 111). The following study steps in generating the substantive theory has been illustrated in Figure 2.11. During the writing of the grounded theory Glaser (1992) provides the following advice to researchers during this stage as “it is a continuation of your writing. You have fractured a story descriptively and are now putting it back together conceptually” (Glaser, 1998, p. 194). Glaser (1998) asserts that in writing the grounded theory, theoretical statements and concepts are presented first and then illustrated with examples from direct quotations from the interviews. Glaser (1978) also highlights the importance of the “carry forward notion” of concepts as this shows the relevance of the developed theory. Throughout the thesis, the researcher has highlighted important concepts related to the developed theory in italics.

2.9 Methodological rigour

To ensure the trustworthiness and credibility of data and transferability of the findings a number of strategies were incorporated throughout the study to ensure that data collection, interpretation and accurate reporting were maintained. As expressed by Streubert Speziale Carpenter (2003) all qualitative research is evaluated for its rigour. Sandelowski (1986) explains that another researcher should be able to follow and understand the logic of the decision making trail. Therefore, memoing, during the analysis process served as an audit trail of hunches, thoughts and lines of inquiry (Cutcliffe & McKenna, 1999; Wolf, 2003). Further, the audit trail documented all descriptions, explanations and justification of decisions related to the study’s phenomenon under investigation. Objectivity was ensured for the duration of the study, by the researcher bracketing her experiences, judgements, beliefs, thinking on the studied phenomenon to avoid any biased, prejudice, assumptions, or pre conceived issues interfering with the findings of the study (Cutcliffe & McKenna, 1999). To assist with this, the process of bracketing, and the use of a journal was utilised to record the researcher’s prejudices and thoughts towards issues pertaining to the study under investigation.

Credibility as described by Sandelowski (1986) deals with the truth value of evaluating qualitative research. Credibility was maintained throughout the research process by representing faithful descriptions and interpretations of the participants experiences described to the researcher. The researcher ensured that all descriptions are firmly grounded in the data and can be traced back to its original text (Koch, 1994). The participant’s experiences have been recorded, reported and transcribed in their proper

context (Chiovitti & Piran, 2003; Poland, 1995; Sandelowski, 1986; Streubert Speziale & Carpenter, 2003). These responses are further verified and confirmed for accuracy of information by independent coding of a number of interviews by the researcher's supervisor (Cutcliffe & McKenna, 1999). Transferability of findings has been achieved by providing thick descriptions of the phenomenon under investigation and providing meaning to others in similar situations for utilisation; so as similar judgments can be made by others (Koch, 1994; Punch, 2005; Sandelowski, 1993; Streubert Speziale & Carpenter, 2003).

As the researcher used the grounded theory method she was also aware of maintaining methodological rigour pertaining to the research study. Criteria for evaluating a grounded theory study have been described by Glaser (1998) as "fit", "workability", "relevancy", "modifiability", "parsimony" and "scope". The researcher was able to ensure that the research study accounted for "fit" and "workability" by adhering to the grounded theory method ensuring that categories were derived from the data and explained the major variations in behaviour from the participants in the substantive area. Moreover, the researcher was able to test the "fit", "workability" and "relevancy" of the theory by presenting data to the researcher's supervisors and to perioperative nurses at conference venues at local, state, national and at an international level (Smith, 2010, 2011, 2012; Smith, Leslie & Wynaden, 2010a). The feedback received confirmed the study findings as they resonated with health professionals' own experiences, both here in Australia and abroad in Canada. The study was also modifiable by the integration of new concepts as they came to hand. According to Glaser (1992) a grounded theory study should be modifiable and easily altered with the addition of new concepts. The criteria for parsimony and scope are met by accounting for as much variation in the behaviour of participants around the central problem, with as few concepts as possible (Glaser, 1998). To achieve parsimony and scope the researcher sought feedback from her supervisor, in addition utilised the feedback provided by other nurses during the various conference events to confirm the study's findings. Further the study's findings were also confirmed later when a comparison of the substantive theory is made with relevant existing theories in the scientific literature.

2.10 Summary

This chapter has provided an overview of the qualitative grounded theory methodological approach chosen to conduct this research study. A background of the original grounded theory method as described by Glaser & Strauss (1967) and further a brief overview of the divergence of the grounded theory method explains why the researcher chose the original or Glaserian grounded theory method to investigate, elucidate and capture in their voice the perioperative nurses experiences of multi-organ procurement surgery. A description of the research process entailed the researcher's steps in seeking ethical approval to conduct the study in addition to steps taken by the researcher prior to going out into the field to collect data such as bracketing researcher awareness and assumptions. During the process of data collection the researcher outlined the setting, sample and recruitment of participants to the study in addition to the various sources of data collected to inform the study in addition to the ethical issues and considerations enacted by the researcher to protect participant's confidentiality. During the process of data analysis the constant

comparison method was utilised in addition to coding techniques to explain the emergence of the core category, the basic social psychological problem and process and the resultant substantive theory. Lastly this chapter concluded with a discussion of the methodological rigour pertinent to the study. The substantive theory of *finding meaning* to overcome *hiding behind a mask* as identified in the data by perioperative nurses participating in multi-organ procurement surgery will be presented in detail in Chapters three, four, five and six of this thesis.

CHAPTER 3

The Basic Social Psychological Problem: Hiding Behind a Mask

"The grounded theory problem and its continual resolution is always there, as participants always have a main concern they are dealing with" (Glaser, 1998, p. 115)

3.1 Introduction

This chapter presents the basic social psychological problem encountered by perioperative nurses when participating in multi-organ procurement surgical teams. Using the grounded theory method the researcher sought to uncover the pattern of behaviours that were relevant and problematic for the study participants by identifying the basic social psychological problem. The problem in grounded theory as Glaser (1998) states "revolves around the main concern for participants whose behaviour continually resolves their concerns. It is what is going on! It emerges as the overriding pattern" (Glaser, 1998, p. 115). In this study it was identified that the basic social psychological problem experienced by perioperative nurses' was *hiding behind a mask*. In addition to identifying the basic social psychological problem, the researcher sought to discover why and how the problem occurred. Quotes from the participant's transcripts have been included to provide rich descriptions of their experiences. Furthermore, the use of relevant supporting scientific literature is also included to support the analysis and trustworthiness of the data presented.

3.2 Hiding behind a mask

As noted, the basic social psychological problem of *hiding behind a mask* was found to be a fundamental shared concern that the majority of perioperative nurses in this study faced when participating in multi-organ procurement surgical teams. Glaser (2001) confirms that "the main concern is a perspective and conceptualization of their voice loud and clear in many indicators" (p. 103). Many of the participants articulated the word "hiding" in response to their participation experiences:

I try to hide behind the mask and not show my emotions ... I often cry when they [the donor] first come [into the theatre] ... it hits you ... this is real ... it's going to happen [the multi-organ procurement procedure] ... there is no going home now. (P25)

Other participants provided examples consistent of the hiding experience: "It's just such an emotional time ... I don't think it showed emotionally or physically ... the sort of thoughts going on in my mind ... (P20); "Hiding behind the mask ... you [as a perioperative nurse] do to a certain extent" (P19). A definition and interpretation of *hiding behind a mask* was sought from the dictionary. To "hide" as defined in the Australian Concise Oxford Dictionary is "to put or keep out of sight ... preventing the disclosure or recognition of ... conceal ... to cut off from sight" (Moore, 2009, p. 664). Further, "hiding" was defined as "the act of hiding

or concealing or withholding from view or knowledge ... concealment ... the act or an instance of hiding ... the state of remaining hidden”(Moore, 2009, p. 664).

A “mask” was defined as “a covering for the face or part of the face, to conceal the identity ... anything which conceals or disguises” (Moore, 2009, p. 874). The above definitions were all relevant of the descriptions provided by the participants within the context of this study. Perioperative nurses denied, concealed, disguised and withheld the impact of their experiences from themselves, their professional colleagues and other members of the surgical teams. Traditionally, within the operating room a mask is worn and used as personal protective equipment against infectious materials. However within the context of this study perioperative nurses used their mask to hide their, attitudes, beliefs, behaviours and emotions whilst participating in multi-organ procurement surgical procedures.

The participants’ experiences of *hiding behind a mask* varied in intensity and frequency. Although many participants had several years of experience as perioperative nurses, their participation in multi-organ procurement surgery remained problematic as each experience and exposure to the procedure was different for them. Therefore, the basic social psychological problem of *hiding behind a mask* was experienced by participants during the procedure each time they initiated care for a new donor. The identified basic social psychological problem of *hiding behind a masks* comprised of three stages: 1) *being unprepared*; 2) *being overwhelmed* and 3) *hiding the burden* (See Figure 3.1). Passage through each stage of the basic social psychological problem of *hiding behind a mask* was sequential with participants spending varied lengths of time in each stage. The majority of the participants had progressed through to stage 3 at the time of being interviewed for this study. However, a few participants were still resolving issues of stage 2 and were still experiencing feelings of *being overwhelmed* and could not move beyond this stage when data was collected for this study.

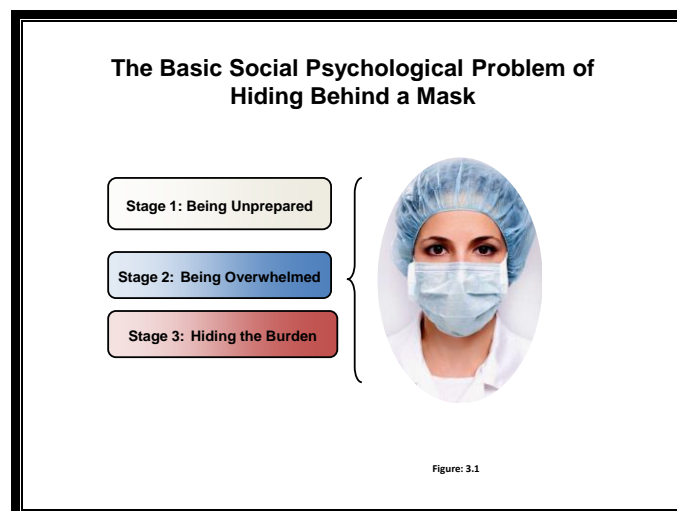


Figure 3.1: Stages of the basic social psychological problem of hiding behind a mask

3.3 Stage 1: Being unprepared

The first stage of the basic social psychological problem of *hiding behind a mask* was conceptualised as *being unprepared*. Three aspects of being unprepared were identified: 1) *exposure to multi-organ procurement surgery*; 2) *being exposed to death* and 3) *the grieving family* (See Figure 3.2). Participants articulated *being unprepared* when they were exposed to *multi-organ procurement surgery*, feeling *unprepared* for *being exposed to death and managing and witnessing* the circumstances of the each donor patient: “Our aim is to keep people alive ... that is what we strive very hard to do to improve their quality of life ... maintain life ... so something like this [multi-organ procurement surgery] is quite hard to deal with” (P18). Participants also felt unprepared when *caring for the grieving family* of donor patients within the operating room.

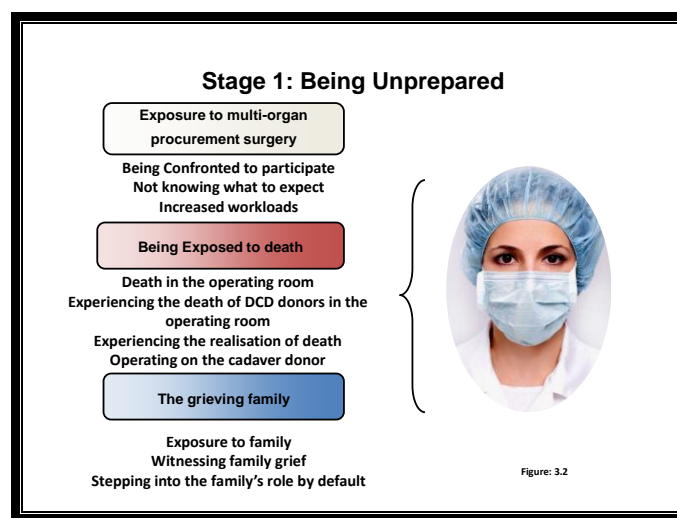


Figure 3.2: The aspects and components of being unprepared

3.3.1 Exposure to multi-organ procurement surgery

Exposure to multi-organ procurement surgery was identified as the first aspect of participant's experiences of *being unprepared*. As these procedures are always unplanned emergency procedures when an organ donor becomes available, for example, following a motor vehicle accident there is no way to predict when perioperative nurses would be asked to participate. As a result their exposure is sudden, confronting and they are provided with little time to prepare personally for the experience. The urgency and unexpectedness of these procedures also adds to the already stressful environment and workload of the operating theatre. This added further to participants feelings of *being unprepared*. *Exposure to multi-organ procurement surgery* was identified as having three components: 1) *being confronted to participate*; 2) *not knowing what to expect* and 3) *increased workloads*.

3.3.1.1 *Being confronted to participate*

The first component of *exposure to multi-organ procurement surgery* was identified by participants as the time when they were *being confronted to participate* in these surgical procedures. Several participants acknowledged that unfortunately a death had to occur before these surgical procedures presented to the operating room: “Someone has died in order for this procedure to be undertaken” (P19); “Sadly, a death has had to take place for this procedure to be possible” (P32). Several participants referred to the suddenness of these unplanned emergency procedures which presented at any time: “It was something that was sort of spur of the moment [unscheduled and occurring] suddenly ... coming to theatre” (P14); “You don’t know when they’re going to come [the multi-organ procurement procedure]” (P28).

Perioperative nurses disclosed that at the time of *being confronted to participate* that they experienced heightened levels of anxiety as they had received no prior indication of their participation. The majority of participants explained that their exposure to these types of procedures were sporadic: “We might have a real run of them [multi-organ procurement procedures] and then we may not ... see another organ retrieval [procurement procedure] for months” (P27); “Sometimes you might go six to twelve months and we don’t do any. Then you might have two or three in a run, so it’s very difficult to know” (P28). When these procedures were scheduled suddenly participants spoke of *being unprepared* as the procedures were of a long duration and the theatre environment was often chaotic and disorganised due to the emergency circumstances surrounding the surgery: “[The procedure] was very chaotic ... very disorganised” (P14).

Other participants described how they kept their feelings concealed *by hiding behind a mask* when they were *being confronted to participate*: “The first time I was thrown in [to the theatre to participate], I was unprepared ... like my god what am I doing?” (P16); “I felt like I was being thrown in the deep end” (P9); “It’s like being thrown into the deep end” (P10). Several participants explained how real their confrontation was as they were often just told by senior nurse shift coordinators to immediately go to a particular theatre to assist in an organ procurement procedure: “Basically you are allocated there [theatre number], off you go and do it [the procurement procedure]” (P13); “We were just simply told that organ retrieval was going to be done in theatre [theatre number]” (P17); “I was just told, we [the coordinator] put you in there [the number of operating theatre to do the procurement]” (P15). Participants spoke of feeling confronted to participate when they were expected to complete their role as a perioperative nurse and do what was required to meet the needs of the department: “I was the scrub nurse, we’re probably talking 20 something years ago and basically it was just ... you’re doing this, no questions asked just get in and do it” (P29). Several participants explained that little had changed over the years. A comparable account was provided by another participant who also provided an earlier experience:

Well back in the 1980’s when I first did them [multi-organ procurement procedures] I was basically just put in a theatre and told this is what we

were doing with little or no experience of this at all and just had to get on with it really. (P10)

Several participants spoke of *being confronted to participate* for the first time when working a nightshift as these procedures were often completed in the middle of the night: “They were done in the middle of the night when I happened to be on night duty at the time ... I had to organise it and work out what they wanted and I got involved in those [procedure]” (P3); “I don’t think in theatre we have got a procurement team ... it’s like the people who work on night duty that mainly do it ... they end up doing the majority of these cases” (P16).

Other participants explained that they were also placed in the situation of *being confronted to participate* when they were covering on-call duties: “Whoever is on call has to do it [assist with the procurement process]” (P24). While they felt unprepared they also knew they had to fulfil their on-call duties: “I was doing somebody else’s call and I got called in to do the organ retrieval for them. I didn’t have an option” (P21); “Whoever is on call has to do it ... I don’t think there was much of a choice” (P24); “I was on call ... I didn’t know what I was doing. I had no idea what to expect at all” (P19). Other participants who had just completed their shift had to return to work when on call to participate in a procurement procedure: “We actually got called back [into work] for an emergency case ... [and we were] told that we had to stay for an organ procurement [procedure] at 2.30am in the morning” (P24).

Some participants were surprised that they were never pre-warned that they may have to participate in an organ procurement procedure when they were asked to complete on call duties: “No one had really told me anything [of what to expect] when on call, so I got called in and was totally unprepared” (P19). There was a belief that this aspect of the on call work was often not highlighted nor discussed as it was perceived this may decrease the number of nurses willing to do this shift. This was emphasised by the following participant as:

Well, I guess it’s hard. I think people don’t realise that they can be called out for something like that, that it isn’t a specialised job and that’s one of the things that I tell people, new people if they go on call that [participation] might be a possibility that they get called out [for] ... It’s never, it’s rarely discussed. (P24)

Another situation where participants felt they were *being confronted to participate* was when they commenced duty in the morning and they had to relieve night duty staff who were often midway through or just completing a procurement procedure:

Mainly [I] came in the morning ... [night duty staff] need to be relieved ... by the time I’ve got there half of the organs were taken out and the remaining few [organs needed] ... to be taken so I was not involved from the beginning ... I would like to do one [a procurement procedure] from the beginning but I have never been able to do it because they always start in the middle of the night and [are] always done in the afterhours ... if you’re not on the night shift you just come in and relieve [night duty staff]. (P16)

Most perioperative nurses experienced *being confronted to participate* when being *exposed to multi-organ procurement surgical procedures* as part of their professional work roles at some stage in their perioperative nursing career. Although some participants had previously assisted with these procedures they reported that with each new experience they still experienced feelings of *being unprepared* and *hiding behind a mask*. This occurred as each experience was different and each donor presented the nurse with different challenges and emotional reactions: “You [may] have years of experience [perioperative experience] ... it doesn’t matter it’s still a different person [donor] so there’s always that aspect [which is different]” (P34).

3.3.1.2 *Not knowing what to expect*

The second component of *exposure to multi-organ procurement surgery* was articulated by participants’ as *not knowing what to expect* when they were required to participate in the procurement procedure. Participants were uncertain of their professional roles in procurement surgery, the surgical procedure itself and the surgical requirements necessary to undertake these procedures. In addition participants also did not know what to expect when working with external procurement teams which often comprised of people external to their work place. Even after their first exposure to organ procurement, each new procurement experience brought with it unique challenges and self-doubt for participants. They were concerned about whether they would be able to perform their role as a perioperative nurse and meet the expectations of other team members. *Not knowing what to expect* was articulated by one nurses as: “I wasn’t given any warnings about what was going to happen [during the procedure] and obviously you realise that you’re taking the organs [participating in an organ procurement procedure]” (P6). Another participant articulated poignantly the internal turmoil they felt:

I didn’t know what to expect. I was like well what do I have to do? ... my goodness I’ve got to scrub for this and I don’t know how to do this ... you’re thinking this is too daunting I can’t do this. (P13)

Not knowing what to expect was also experienced by more senior nurses who indicated that not every perioperative nurse would have experience in multi-organ procurement surgery as these procedures usually occurred at specifically designated public hospitals. Therefore, some perioperative nurses exposure to these surgical procedures was described as limited: “We don’t do enough of these procedures” (P16); “Being so inexperienced it’s hard ... you feel so unprepared” (P9). A lack of exposure and experience was a common theme reported by participants who had previously worked in the private health care sector:

I didn’t really know about organ procurement until I got here * [Name of Public Hospital] because I worked in the private sector, you don’t get any of that sort of exposure. It wasn’t until I was confronted with it [the procurement procedure] that I was like okay [I’m] coming in to do a procurement and I don’t know anything about it. (P19)

Similarly participants who worked in the smaller regional and rural hospitals also reported limited experience and higher rates of *not knowing what to expect* when asked to be involved in these surgical procedures due to limited opportunities as the prevalence of these procedures was much lower in incidence than the major metropolitan regions. Therefore they reported increased levels of uncertainty of procurement surgical procedures when interviewed for this study:

Well, I knew from a community sense that it [procurement surgery] occurred but from a theatre [operating room] point of view, I hadn't been involved nor even heard of it occurring very often. I mean, given the number of deaths that would have occurred in the * [name of] hospital at that time there didn't seem to be far too many organ retrievals passing through theatres. Not many at all ... this was the first [procurement procedure] in the time I was there, [in] two and a half years ... only one [procurement procedure] ... and I didn't know what to do. (P27)

In country areas a small number of experienced perioperative nurses routinely participated in these specialised procedures. As a result, there were limited opportunities for newer or more junior nurses to be exposed to this type of surgery during their employment at these hospitals. This lack of exposure became problematic when the experienced staff members were not on duty or were on leave as it meant that the inexperienced nurses had to step in. A lack of knowledge left them *not knowing what to expect* as the following account describes:

You never know what to expect ... you don't know when they're [procurement procedures] going to come ... It's very hard though [when working] in a country area because if you've only got a few [perioperative nurses] that are [routinely] doing it [the procurement procedures] and you don't know who is going to be on duty at the time ... one of them [the experienced nurses] could be on holidays or leave ... I happened to be there for a couple [of procedures] and it was difficult [not] knowing what to do ... whereas there are people [nurses] who have been here at the *[Name of Hospital] for years and still haven't done any ... however, this nurse that ... only recently [commenced work] walked straight into one. (P28)

Therefore during a procurement surgical procedure the perioperative nursing staff often had different levels of experience and skill mix with many of them having limited experience in assisting with procurement surgery: "We don't have regular staff who do them ... we don't have a [set] procurement team" (P16). As a result, when the procedures were suddenly scheduled participants described there was often uncertainty as to what was required: "When we do have them everybody is not really quite sure what to do ... it was all a bit like a mad rush ... and the people that I was working with hadn't done one either so they were really unprepared" (P31); "It's more about ... you are not doing it every day, it's that routine of not exactly knowing exactly what to do" (P7).

Not knowing what to expect predisposed participants to be *hiding behind a mask* as they spoke of hiding their lack of experience from other surgical team members. One participant described the experience as: “[It] was chaotic and I didn’t know what to expect [when participating] ... I didn’t tell them that I hadn’t done one before ... as there was no one else to do it” (P14). They hid behind a mask as they did not want to bring attention to themselves and have members of the team doubt their abilities to successfully assist in the procedure. One participant provided the following experience:

[I] was working with surgeons from * [Name of another Hospital] that I’d never met ... I was more [worried] initially, it was the fear of the unknown. You ... get thrown into a procedure that you’ve never seen and you’ve never done and then the fact that it is fairly full on in the sense that you know pretty much nothing ... [The donor] patient is opened up [motioning with her hand the surgical incision] from head to toe and everything [organs] are basically taken out. (P19)

This concern was further raised by other participants as being particularly a problem when working with visiting procurement surgeons from the various procurement teams. As these surgeons were often external to the hospital, participants had not previously worked with them and were therefore not familiar with their surgical practice and preferences as well as their expectations of the perioperative nurse: “If you were doing it ad hoc ... I’d probably find it quite hectic like because I don’t know the [surgeons and their] way of doing it [the procedure]” (P23). In such circumstances perioperative nurses were not able to familiarise themselves with the surgeon’s preferences via preference cards as there were none available which outlined their choice of equipment and any specific requirements as usually available for other surgical procedures. As there were so many different surgeons involved in procurement surgery, there were usually no specific surgeons’ preference cards to refer to. This was described by one participant as: “I was a bit anxious ... I was unfamiliar with the surgeon’s needs and what was expected of me” (P24). Participants further elaborated that they found this aspect of working with external surgeons from other areas difficult:

You are just going to be the circulating nurse and just be there and give them [external procurement surgical teams] what they would like, like you would with any other [surgical] case. That was really how it was delivered to us [perioperative nurses]; treat it like it was any other case. Obviously it isn’t like any other case and basically ... you are in there and you go and do it. (P13)

Participants reflected that being immersed in a procurement surgical procedure when they felt uncertain, *not knowing what to expect* throughout the surgical process was difficult: “I didn’t know a thing” (P16); “I didn’t know squat [anything about the procedure], I just went in there [to theatre to participate in the procedure]” (P14). Other participants articulated for example, not knowing the exact sequence in which the organs would be procured and therefore, were uncertain of the surgical process and what instruments and equipment to prepare: “I think that was my initial problem, I didn’t know what was happening [during the surgical procedure] because I was just shoved in there [into the theatre and told], get on with it and I didn’t know what was going on” (P1). This resulted in several participants

experiencing heightened levels of anxiety and stress during the procedure and *hiding behind a mask*. One participant disclosed that she was shocked at how quickly the procurement surgical procedure was undertaken: “It was just a bit of a shock how quickly the process [the procurement of organs] occurs” (P12).

The urgent nature of the procedure added pressure and stress on participants to ensure that they had all the necessary equipment available that the surgical teams would require to conduct the procurement surgical procedure: “You focus on the procedure itself ... on the requirements of setting up and providing the appropriate equipment or making sure it’s all in place ... your mind is too occupied making sure all is in place so that the exercise turns out to be successful” (P17). A similar account was provided by another participant:

I find you’ve got so many other things to do, like the needs of your cardiac team as well. You can barely move sometimes, just eskies everywhere ... it’s just hectic, very hectic and like once you start doing it [the procurement procedure], it always has to happen in such a hurry ... you have to be very organised [little laugh]. I ... find, I try to lay things [instruments] out [on the surgical table] as much as possible and to have everything available, but I never do. (P9)

As a result of *not knowing what to expect* some perioperative nurses did not have all of the necessary equipment for the procedure readily available in the theatre during a procedure. This experience of not having all the required equipment was reported by a number of participants who worked in the smaller rural hospitals: “The donor coordinator ... she said all you need to do is put the blade on your chest saw!” and I looked at her and said “We don’t have a chest saw” (P24). Another participant elaborated that as the specialisation of cardiothoracic surgery was not routinely undertaken in their hospital they did not keep chest saws within the theatre complex:

When we did that first one [procurement surgical procedure] we didn’t have cardiac and thoracic [specialties] happening either. We didn’t really have the staff that had the chest, cardiothoracic experience and I scrubbed for that one ... I came on a late shift we had been allocated to that theatre. (P18)

A study by Wang & Lin (2009) on six perioperative nurses experiences in organ procurement in Taiwan, reported similar situations with participants struggling with not knowing what they were doing when participating in these surgical procedures. As one respondent described: “Actually, I didn’t know what I was doing during ... through the whole progress of organ procurement. All I remember was constantly chipping away at ice” (Wang & Lin, 2009, p. 280).

3.3.1.3 Increased workloads

The third component of *exposure to multi-organ procurement surgery* was identified by participants as *being unprepared for dealing with increased workloads* due to their participation in procurement procedures. As these procedures can take up to five hours to

complete, several participants reported having to contend with *increased workloads* and increased activity within the workplace: “They [procurement surgical procedures] took a long time ... and we also had other emergency cases to undertake so it was really busy” (P24).

The complexities of staffing procurement procedures was emphasised by several participants: “Sometimes there is staffing issues, sometimes you are working a little bit short but that would be across the board [in all theatres]” (P9); “There is never enough staff to cover elective lists as it is ... so when we get a procurement procedure this adds to the staffing problem” (P9). Several participants explained that procurement procedures often took up valuable theatre time and it was difficult to find staff for these additional procedures at such short notice: “So it’s all very higgledy piggledy ... who ends up doing it [the procurement procedure] or who doesn’t ... it depends on who is available at the time ... or finding available staff” (P24).

Participants emphasised that when they were required to assist in these emergency procedures they were often undertaking other duties and already understaffed. This additional workload added considerably to their level of stress: “So I’ve had that [experience] of additional workloads but of course it just makes it a bit busier when you have less staff available” (P9). As a result several nurses described these situations as: “It was so hectic ... we had to juggle other emergency procedures and we were already short staffed” (P24). Other participants also voiced that *increased workloads* were a major hindrance to their participation in these procedure: “I think the only hindrance was not having enough staff at times because you are [working] after hours and you’ve got restricted staff and you might have other areas working [theatres in use]” (P3).

In staffing theatres for procurement surgical procedures, hospitals were reported to have dealt with this problem by increasing existing staff workloads, and working with minimal staff in other areas, placing all staff under extreme time pressures as one participant explained: “It was stretching staff resources” (P15). Other participants felt unprepared to participate when they were pulled out of their scheduled surgical lists to assist in procurement procedures at short notice: “You are just getting on with your normal list and then you’re being pulled out to participate in a procurement case and again you’re out of your comfort zone” (P7). The same participant emphasised this point:

They might get an extra one nurse in [from another theatre] but its dragging staff off the floor, so there might be a team in the theatre but all the other theatres [and nursing staff] get reduced [in other areas to accommodate procurement surgery]. (P7)

Increased workloads were also reported by other participants who held other perioperative nursing roles such as in middle management and staff development. These nurses were called upon to assist with procurement surgery at the time these procedures were required to cover departmental staffing needs. This was noted by the following participant:

I know once they must have been extremely short on the floor [within the operating room] because * [name of a nurse] and myself we both [worked] in a staff development role but we were pulled out of our roles and offices, which we were more than happy to do but obviously we were very short staffed that particular day ... That puts that little bit of extra pressure on [us] without a third nurse available to help us. I also understand if from their [management] point of view that if they could not staff it any other way [then] part of my job role would be to actually be involved in that case just like if any other emergency case came [through the operating room doors] I would have to work in that case because that's my shift. (P12)

Moreover, participants understood the necessary need to rearrange staff workloads in order to staff the *increased workloads* placed on the department by these emergency procedures: "It's part of my job and role ... to work and do whatever [cases] are required to be undertaken on my shift" (P12). If necessary staff who were off duty were called in to staff the theatres for the procurement procedure at the larger metropolitan hospitals: "Then you have to get enough staff or call someone in to do the case ... we called someone in at that time" (P35). Similarly, this was also validated by another participant from a smaller regional hospital who reported poor staffing issues and the need for off duty staff to be called in for these surgical procedures if and when they were required:

Like in a country hospital ... the way it works here *[Name of Hospital] ... there's only enough [staff] to run one theatre ... so if we get a trauma or a procurement [procedure] the staff will be called back in and there's only like I said one registered nurse here over night sort of thing it's hard [work] ... it's the same on the weekends. (P25)

Staffing shortages in the perioperative environment has also been reported as a nationwide problem (Australian Institute of Health and Welfare, 2011). Other authors attributed nursing shortages globally in the operating room specialty to an ageing workforce and the changing environment creating increased workloads, patient care demands, and practice issues which impacted on the retention of perioperative nursing staff (Hayhurst, Saylor & Stuenkel, 2005; Shermont & Krepcio, 2006; Trice, Brandvold & Bruno, 2007). Perioperative nurses reported increased levels of stress at being overworked (Allen & Beyea, 2002; Bull & FitzGerald, 2004a; Michael, 2001). Allen and Beyea (2002) reported that 80% of perioperative nurses reported "grave concern about their ability to provide safe care after prolonged hours of work" (p. 9).

Participants interviewed for this current study also spoke of frequently being required to work overtime to absorb the additional workloads within the daily scheduled activities of the operating theatre. These participants reported that after they had worked a full day's shift they were placed on call that evening and were made to participate in lengthy multi-organ procurement procedures until the early hours of the following morning as one participant explained:

You know ... your exhausted and it's going to go into the early hours of the morning and that's after sort of working the full day and knowing you're on

call for other stuff [emergency procedures] as well so ... we've had two [procurement procedures] recently that have been pretty close [together] and sort of full on. (P28)

The research study by Wolf (1994) investigating nurses caring for non-heart beating cadaver donors also reported frustrations at staffing levels when caring for donors as: "You get pretty frustrated when you're working all night long, and you're standing there, and you didn't eat, and you didn't even go to the bathroom ... " (p. 979).

In this current study, participants also described negative effects on their stress levels and moods due to the cumulative effects of working for extended periods of time while dealing with the emotional and often traumatic impact of these procedures. Therefore, some participants felt unprepared and unable to cope with the increased workloads and expectations placed upon them. The likelihood of being asked to follow on and assist with a transplant surgical procedure was also emphasised as something that could occur in the work environment:

That's where my attitude is like retrievals are shit just because you've got them [the procurement procedure to do] especially if then, you ... follow on with a transplant [procedure] ... I mean the thing I don't like about them [procurement procedures] is the fact that then we might have to do a transplant the next day and it mucks up our lists ... I think you should have designated theatres and staff to do that because that's more practical ... it just ... buggers up the next day's list with staffing and it stretches the staff out again the following day. I'm quite happy for it all [to take place] except for the impact on me personally with my workload or the workload of the whole place [the theatres] and that's what I find annoying. (P7)

Participants stated that the *increased workloads* were often viewed by others as normal working conditions for the perioperative nurse: "It is always busy in theatre regardless" (P35). However, within this study participants disclosed that *increased workloads* heightened their levels of anxiety and affected them emotionally and physically impacting on their health and well-being: "I felt emotionally drained and physically exhausted ... it [the procurement surgical procedure] was just so busy and quick" (P19). Similarly, other authors also emphasised that procurement procedures created extra work and stress for the surgical team members involved and were emotionally draining for healthcare workers involved in these procedures (Gross, Marguccio & Martinoli, 2000).

Participants most often chose to conceal and repress their feelings of being overworked within the operating room environment whilst *hiding behind a mask*: "It was stressful ... not only what you were doing [the procurement procedure] but having to work on your own if there was no staff available" (P16). Generally, participants choose to never express verbally the impact that increased workloads had on their well-being to their line managers or their fellow colleagues as they felt that they would be viewed as not being competent to cope as a perioperative nurse. Participants also expressed that they could not voice their concerns to their line managers as they knew there was lack of staff available to undertake the additional workloads: "You couldn't complain about it ... you knew it was going to fall on deaf ears as there was no one else to assist you" (P16).

Several nurses found the *increased workloads* extremely difficult to manage: “It’s hard ... there’s just so much work and there is little support ... there is nothing you can do except do the best that you can with the staff you have” (P15). Other participants spoke of feeling angry at having to contend with increased workloads but bottled this anger up within them whilst *hiding behind a mask*: “Some of us [perioperative nurses] get cross ... just for the fact you’re in there doing procurement [surgery]” (P7). Moreover the same participant explained that she felt resentful at having to contend with *increased workloads* and staff being stretched in all areas of the operating room department due to the need to accommodate a procurement surgical procedure:

I get a bit resentful because the [theatre] staff often get stretched too, because it’s an extra theatre [running] or there is an extra two theatres going so your staffing gets pulled [due to the increased workload]. So you might end up with two people in your theatre instead of three and that sort of being an extra work load that’s the usual problem. (P7)

3.3.2 Being exposed to death

The second aspect of *being unprepared* was when participants experienced *being exposed to death* and this aspect had four components: 1) *death in the operating room* and 2) *witnessing the death of the DCD donor* 3) *experiencing the realisation of death* and 4) *operating on the cadaver donor*. *Death in the operating theatre* is a rare occurrence and so many participants when faced with death were unprepared for it when it did occur. In particular, participants were unprepared for witnessing the death of DCD donors within the operating room environment as these donors were not yet deceased unlike the brain dead donors who were deceased but were ventilated to preserve the integrity of their organs. Similarly, participants found both donors and the multi organ procurement process difficult to witness as donor patients in both circumstances still were reported to look alive and unconscious and were visibly warm to touch. Therefore participants found it extremely difficult caring for the donor’s body during these procedures and found this aspect particularly stressful.

3.3.2.1 Death in the operating room

Death in the operating room was described as the first component of *being exposed to death*. Participants articulated a *death in the operating room* as: “An event in the operating room which was out of their control” (P12). The participants explained that their work primarily fixed people or saved lives and while some patients die in the operating room as a result of trauma this was a rare occurrence: “I have had traumas in theatre where the patients die but usually you can see why they have died because of the extent of their injuries. In reality I’ve had very few deaths [of patients dying] on the [operating] table” (P29). However, participants in this study described that when a death did occur, they felt uncomfortable and upset: “When we’ve [had a] death in theatre ... it’s uncomfortable and nobody likes it” (P13). Participants pointed out that they felt defeated when they lost a patient during an operation: “I always hate losing patients [when they die during an

operation]” (P19). One participant gave this example of the impact of experiencing a death in the operating room on her:

I remember a particular case ... a patient coming ... her aorta was punctured. She died on the table it was horrific and thank god you know it doesn't happen very often. The whole thing you know your adrenalin is going because you are trying to do all your patient resuscitation, everything you can do. We had to rush to open the patient's [abdomen] ... to try and control the bleeding and she bled out [and] she died. (P13)

Similarly, another participant recalled the following experience:

I remember working one weekend and we had a woman [a patient] come in and she [had] collapsed at work. We tried everything to save her and she was fairly young and you know we lost her [she died]. Some people were like falling apart and couldn't stay the rest of the day at work. They had to go home and they were devastated because there was a death [in the operating room] (P14).

When a death did occur on the operating table, each member of the team dealt with this event differently and some team members preferred not to speak further of the incident. Health professionals such as nurse anaesthetists in the study by Booth (1998) also described unexpected death as having a “profound and personal effect on nurses” (p. 52). Similarly, in this current study, several participants simply choose to internalise the experience and hide behind their mask as one participant described:

I know we had a case a while ago with a young bloke ... apparently it was quite a horrendous situation in theatre and he died. There was one girl [a nurse] who was sort of only on the outskirts [not really involved with the procedure] but it probably affected her more badly than anybody and she felt silly for that. I think it is that ... we [nurse] don't allow ourselves to feel emotional about people dying ... you don't talk about it, it's not discussed, and it's not like a big or our main focus [as perioperative nurses]. Our focus is on what we can do to make sure that [death] doesn't happen and to keep people alive. So we don't actually talk about how we deal with death. (P18)

Participants reported that being exposed to an unexpected death of a patient during an operation was often more distressing than coming to terms with a donor's death from a multi-organ procurement procedure. As one participant delineated there was no expectation of life for these donors: “With the multi organ [brain dead donor] they are already [dead]. We have a little bit of insight as to how the patient had died” (P18). Another participant provided the following view:

The patient is already [brain] dead so you're not really participating in the actual demise of the patient ... the patient has already been classified or clarified as being brain dead so therefore you are just fulfilling their [the donor patient's] wishes. (P34)

3.3.2.2 *Witnessing the death of the DCD donor*

Witnessing the death of the DCD donor was identified as the second component of being *exposed to death*. Prior to the surgical procurement procedure taking place on DCD donors these patients arrived to theatre and they are disconnected from their life support. As it may take up to 90 minutes for cessation of life to occur these procedures were described as more intense and emotionally charged: “It was difficult to be part of it ... seeing the donor patient alive one minute and gone the next ... all of this occurring in the operating room” (P24). For several of the participants this waiting and then experiencing the death of the DCD donor was reported as difficult as many of the nurses were with donors during this time: “It is more difficult watching someone [the donor] like waiting for them to die, to do it [to expire], that’s probably [the hardest part], but to me they’re [DCD procedures] more difficult” (P28). Another participant gave this perspective:

They just let them [DCD donor] die on the [operating room] table ... It’s more emotionally draining for the theatre staff because it’s easier to be able to keep yourself walled off when there is just an unresponsive person, you don’t make an emotional connection with them. (P26)

Participants also found it difficult to care for donor patients when they had previously assisted in caring for them during other lifesaving surgical procedures. These nurses felt unprepared for the emotional onslaught that followed as they had a connection with these donors and their illness progression. One participant talked of being involved in a donor patient’s surgery on two other occasions to save his life only for his condition to deteriorate and then having to deal with the patient as a DCD donor:

To be honest I was a little bit sad, I think because I had scrubbed for the donor’s initial cases and he was fine [after these procedures]. I think it was just that little incident [deterioration after surgery] that he had that really made the outcome bad ... I did his initial surgery and then we removed some of the ECMO lines. So I dealt with him a little bit beforehand. It was bit sad ‘cause he was so young ... I think after, that day, that afternoon I was ... a little bit upset about it, a little bit emotional. (P31)

Moreover, the same participant recounted the emotional turmoil and sadness associated with witnessing the cessation of treatment on the DCD donor and the trauma associated with witnessing this event:

Just overall I think I was a little bit sad because a week ago they’d said he [the donor] was doing so well and then in a few days he’d really turned around [deteriorated] and it wasn’t really expected ... what I did think was odd probably [and] harder though is that they actually started to cease treatment in the anaesthetic bay where as they usually I think they do it in ICU. So we had part of our team, the perfusionist, the anaesthetist were both on the other side [in the next room] ceasing treatment who we could see found it quite emotional. (P31)

Participants in the study by Regehr et al. (2004) also provided a similar experience of being involved in a donor patients surgical procedure to save his life just a few days earlier as: “But it’s somebody’s death and like any other death, it’s kind of hard to look at somebody you’ve nursed before ... and we end up taking his organs out” (p. 433).

Within the current study, participants also articulated that they felt they had no control over DCD procedures unlike the brain dead donors who were already deceased. DCD procedures were described as unpredictable and emotionally charged, as participants were never certain of whether the donor would die within the specified time. In addition participants reported mixed emotions, guilt and conflicting thoughts whilst waiting for these DCD donor patients to pass away. This event was illustrated by one participant who described her experience, which was very emotive to the researcher by the following comments:

I think, I’m personally [pause] I’m very emotional. I can cry now even at recalling the event. I felt really down, I don’t know it was surreal I felt really down, exhausted and stressed. I sort of felt guilty and I’m not the kind of person who would wish someone to die because, ... one side of me is more like well if he’s [the donors] going to die I hope it happens, he stops breathing within the 60 minutes rather than longer, because I don’t know what will happen after this time. (P32)

Moreover, the same participant spoke of being unprepared for *witnessing the death of the DCD donor* when it took the patient some time to die and participants found these experiences as unbearable *hiding behind a mask*. One participant described the experience of the surgical team waiting for the DCD donor’s death:

Last week there was a patient, a cardiac death donor [DCD donor] and we did all that waiting for his death, he was in the anaesthetic bay and there were many people around him, there was a whole bunch of people inside [the theatre] and they were all ready waiting [for the death to occur], just waiting and then he stopped breathing [he died]. (P32)

Other participants spoke of feeling unprepared by these situations when surgical teams’ members were often waiting with uncertainty as to whether the donor patient would die and whether the procurement procedure would take place. These periods were reported as stressful which only amplified the levels of anxiety experienced when watching a DCD donors start to deteriorate and then suddenly they would come to life again during the 90 minute waiting period:

He [the donor] was going to be a DCD donor ... they decided to cease treatment ... in the anaesthetic bay ... I was going to scrub for it ... we were in theatre scrubbed ready to go just waiting and then the coordinator came in and said “This is what his pressure is like and he’s still breathing” and the surgeon said “I don’t think he will die within the hour.” This was a shock because they told us at the beginning they thought that he [the donor]

would probably die within 5 or 10 minutes [after ceasing life support]. They thought it would be quite a quick death but it was the opposite. (P31)

Several participants, as a result of *witnessing the death of the DCD donor* were deeply moved emotionally by being there to experience these donors' deaths. Several participants were conflicted by witnessing the withdrawal of life support. For one participant she had likened this process to euthanasia by using the term "killing" the patient. The following participant expressed this as:

I can't believe I've just done that [witnessed and assisted in the DCD procurement surgical procedure], you know that someone has died in our hands and all ... I do good things at work ... like I keep saying curative procedures, I'm not there to see anyone [a patient] die ... we are not curing [the donor], we're killing someone [the donor] and you know it's very hard to come to terms with it [experiencing the death of the donor]. (P29)

Similarly, for another participant *witnessing the death of the DCD donor* made her question her role and whether she was assisting in facilitating the donor's death. The participant provided the following viewpoint however it is worth noting that this participant also struggled with the broader moral issues around procurement surgery, treatment withdrawal and euthanasia:

I was watching a documentary ... and intensivists where on this show ... they acknowledged that it was a very grey area and it's horrible ... I think that, that grey line is very murky and I think we're starting to tread into areas that are very, prone, fraught with dangers, moral dangers ... They say we have very sick people in cancer wards and we're not allowed to hasten their painful deaths. We're not allowed to assist suicides but there is a ... person, unconscious, not in pain and yet we're facilitating their death. I believe ... double standards are starting to come into health. They will let somebody who is completely comfortable die because we have a use for their organs but somebody who is screaming, saying kill me and let me die and we can't do [allow] it. (P26)

Within the literature, participants in the earlier study by Wolf (1994) also felt aggrieved by witnessing the withdrawal of life support. According to Wolf (1994) he stated the following:

Some of these nurses equated taking patients off ventilators with murder and did not want to be seen as executioners or "death nurses". They compared this participation in life-support withdrawal to the role of the well-publicized "death-doctor" who teaches patients how to commit suicide. (p. 974)

Similarly, within the current study, when the DCD donor did not die within the specified time period, participants felt unprepared for these situations reporting this event was like an emotional roller coaster. Therefore *witnessing the death of the DCD donor* procedures were also very fluid and did not always go to plan such as when donors did not die within the specified time. On these occasions the procurement procedure had to be aborted: "She

[the donor] didn't die ... the DCD donor they brought her from intensive care into the theatre, into the anaesthetic bay, extubated [her], [she was] expected to die [quickly], and she didn't and [she] went back to intensive care" (P30). Another participant described a similar situation:

We did have ... a cardiac death [DCD] donor... they brought her down [to theatre] and when they took her off life support she just kept breathing so it didn't actually eventuate [the death of the donor] ... I know some of the staff found that very difficult the fact that like she didn't ... actually die. (P28)

These situations were difficult for both the surgical team and the family who had to witness this event: "Well because that is what they would expect, that is what everyone [surgical team and family] is expecting ... and possibly hoping for ... but if the unexpected [meaning the death didn't occur] didn't happen that's harder" (P30). The whole team was affected by the unexpected nature of the DCD donor not dying within the specified time period. One participant provided an overview of some of the surgical teams' reactions to this situation:

They brought the patient down to our recovery [area] and took her off the ventilator down there in recovery ... and the co-ordinator just kept on coming in [to theatre] and saying "Oh well, 30 minutes" giving us time frames and saying "Oh she's going down [the donor is dying]." And then all of a sudden she'd kick back up and get to a certain level and her body just, pulse kicked in ... and then when she didn't die they [the procurement surgical teams] got unscrubbed and went and had a cup of tea and had some food and went back to [their hospitals] and they were a bit disappointed [that the procedure could not take place as the donor did not die]. Especially one of the doctors because she didn't want to come and sit with everyone else she went and sat by herself and beforehand she was talking with us all and then she sort of went off by herself [as she was upset] ... the rest of us we sort of went oh well this is how it is [accepting of the fact that the DCD donors death did not occur], and it [the procurement procedure] couldn't go ahead. (P27)

3.3.2.3 Experiencing the realisation of death

Experiencing the realisation of death was identified as the third component of *being exposed to death*. Although several participants understood that donors were deceased prior to procurement surgical procedures taking place, they articulated this period as the nurses own moment of confirming the death of the donor. Several participants articulated that they felt unprepared when *experiencing the realisation of death* which they explained occurred throughout certain stages of the procurement surgical process.

Participants articulated *experiencing the realisation of death* at the time of cross clamping of the donors aorta and the excision and removal of the donor's heart was viewed as symbolic of the donor's death: "For me it was at the crucial bit at cross clamp ... when they were taking the heart ... that was a significant moment as death occurring" (P24). Other participants also referred to the excision of the donor's heart as the moment of death:

“Rationalising [between] life and death, when taking the heart was the moment which signified the death [of the donor] (P29). This was also reported by participants as the moment the donor’s soul departs from the body: “A lot of people see the heart as where your soul is” (P29) and “It is the time when the soul leaves the body” (P24). Within the literature similar findings were identified in the phenomenological study by Wolf (1991) who reported that nurses saw the donor as a “sacred being” (p. 83) and “When the heart and lungs are removed, however they are struck by the emptiness of the chest cavity” (p. 83). A participant in the study conducted by Wang and Lin (2009) also stated:

I was very moved when I handed over the heart that time. When I took it out from the heart donor, it was still beating slightly, which made me feel that life can carry on by living in another body to have a new value in life. (p. 281)

In this current study, another scenario of *experiencing the realisation of death* also occurred when participants described the change of atmosphere within the operating theatre, for example, when the ventilator and monitoring was switched off as the moment of *experiencing the death* of the donor: “That’s it... and then you realise everything goes silent [the monitoring is switched off] that’s really quite an eerie sound [the silence], the donor is dead” (P1). Other nurses reported the switch off of the ventilator as the finality of the donor’s death: “It got very quiet you know once they turned all the machines off” (P19). Other participants spoke of *experiencing the realisation of death* at the time anaesthetists left the operating room: “... and then it was amazing just watching all the anaesthetists leave” (P19). For other participants, having not expected this to occur this was a surprising event which only reinforced the reality of *experiencing the realisation of death*: “The anaesthetist says ... ‘Okay I’ve turned [the ventilator off and taken] him [the donor] off now and that’s that’... He’s basically done his job and he leaves the place [the theatre]” (P26). One participant described this experience as:

This is where it really hit me ... I saw the anaesthetist walk out [of the theatre] ... and I said “What are you doing?” And they were like “Well the heart has been dissected or whatever and there is no business for us to be in here anymore ... So that was the bit that really hit me ... this patient is truly dead. (P21)

For several of the participants these experiences were overwhelming as they reported feeling alone, displaced and abandoned by the surgical team members at the completion of the procurement surgical procedure only to be faced with the realisation of the donor’s death:

The heart gets [placed] into an esky and they all trundle out of the theatre in great haste and you’re left there with the lifeless patient ... you are faced with the patient [the donor] who is deceased. (P26)

This experience was similarly expressed by another participant:

The entire ... team has just left and at that moment we go okay that's real, that's it, this person is now no longer complete. It was kind of, it took me a moment to digest that ... the actual experience ... it was quite numbing. (P6)

Within the scientific literature, other authors also validated the current study findings. A perioperative participant in the study by Wolf (1994) stated: "To see an ECG on the screen and an anaesthesiologist standing there, but he is not doing anything, and he's the first one to walk out of the room. It's really weird" (Wolf, 1994, p. 977). A similar response was provided by a participant in the study by Carter-Gentry and McCurren (2004) who noted the anaesthetist leaving the room as the moment of finality: "That is it?" (p. 425). Hagan (1997) a perioperative nurse, also validated this aspect when she wrote about her own experiences stating: "When all the organs are harvested, the anaesthetist will shut off all life support and there will be silence. A silence so loud it's unbearable to our ears" (Hagan, 1997, p. 32). Other authors such as Lilly and Langley (1999) in writing about the experiences of perioperative nurses also made reference to the eerie silence encountered when ventilators were switched off as:

After the anesthesia [sic] care provider turns off the ventilator and exits the OR, each team departs as the organs are recovered and the team is no longer required for the procedure. The resulting silence can leave an eerie feeling that is unfamiliar to most OR nurses. (Lilly & Langley, 1999, p. 790)

Within this current study other participants reported *experiencing the realisation of death* when the removal of the donor's vital organs took place and they looking into the donor's empty, organ less cavity: "I found it just kind of hits you ... the organs are out now ... the patient's dead now ... I don't like that bit ... its facing reality" (P9). This experience was further validated by another participant who found the completion of the surgical procurement procedure difficult to come to terms with:

The last part of the procedure when finishing [removal of the last organs] and when you see into the abdominal cavity [and] where the heart has been removed, the lungs and other related organs removed ... when you see a big cavity towards the end of the case you feel strange ... and before closing because it's just one big cavity, it's like a big tub [referring to the cavity], it's empty and then you look at the anaesthetic machine and there is no activity there is [no monitoring as it is switched off]. You are the only people [surgical team who are left] in the theatre ... with the donor who is dead. (P16)

The conclusion of the surgical procedure, at the time of removing the surgical drapes to uncover the donor was also reported by some participants as the time of *experiencing the realisation of death*: "Removing the surgical drapes is the time it really hits you ... seeing the donor ... that is when death stares you in the face" (P16). This was overwhelming as up until then the donor's body was covered with surgical drapes and therefore many of the visible effects of their death and the changes to their body were hidden from view. As one

participant described there was a noticeable change in the donors appearance: “A young boy ... when we took the drapes off him and I just sort of looked at him and I thought geez he’s skinny. And of course he’s skinny we just took all his friggin [slang word] organs out” (P7). Similarly, another participant spoke of the difference in the donors facial features:

That you can actually physically see when somebody is on the table and they have harvested all the organs and everything is turned off that there is a difference, a remarkable difference in their face that you can only describe it as being the spirit has left the body and you know that’s how it looked to us. (P11)

Similarly other participants described the difference in the donor’s body temperature as the realisation of death: “If you’re touching [the donor patient] it’s just cold, the [donors] whole body is just so cold” (P16); “It’s like that sign of body death ... the body is cold and lifeless ... I suppose is the only way to describe it” (P19). Participants were also faced with having to care for the deceased, cold and now lifeless patient:

Probably one of the hardest things to do is ... with cleaning of the [donor’s] body at the end [of the procurement procedure] ... it’s when you’re actually cleaning the body at the end and it all looks so white, pale, and feels cold ... I don’t like ... rolling and holding a cold body and your trying to clean everything [blood and fluids off the donors body]. (P9)

Similarly, a respondent in the study by Watkinson (1995) also identified this moment as the death of the donor: “It was when we had to lift him off the operating table he was light, empty, and that sort of brought it home really” (p. 936). Similarly, external to the operating room environment, some nurses also emphasised that absolute death occurred when these procedures were completed. This was emphasised by a participant in the ICU study by White (2003) who also held the perception that the brain dead donor was in fact dead when: “... so the absolute time that he is completely dead, as a complete organism, is when they’ve finished the operation” (p. 12).

Moreover, within the current study participants described the time a donor was placed in the shroud to be taken to the mortuary as symbolic of *experiencing the realisation of death*:

The moment we put her [the donor patient] into the shroud ... she looked a little bit hollow [her abdomen]. I suppose, it was strange ... we had taken so much out [organs from her body] and then she was taken to the mortuary ... so it was really over now. (P21)

3.3.2.4 Operating on a cadaver donor

Operating on a cadaver donor was identified as the fourth component of *being exposed to death*. Participants articulated that a multi-organ procurement procedure is the only time when perioperative nurses have to assist in *operating on a cadaver donor* patient. Although multi-organ donors are deceased and are confirmed either brain dead or have died as a DCD donor, these donor patients are treated like any other patient on the operating table.

For example, they are positioned, prepped and draped to prepare them for surgery. In addition, perioperative nurses continue to conduct their routine practices of counting instruments and maintaining standards of sterility to ensure that the organs are procured successfully and do not become infected or damaged. However, for some participants, it was difficult to undertake their duties knowing they were *operating on a cadaver donor*. One participant described it as eerie:

It's the same as any operation ... you're doing what you would normally be doing [the donor is on the table, you have prepped and draped as usual] but the patient is not breathing [is no longer ventilated], he's not [alive], nothing is happening ... it's odd ... operating on a deceased person, it's eerie, it's a bit eerie, and that's what it is, it's eerie. (P30)

Several participants were uncomfortable when placed in the position of assisting with *operating on a cadaver donor* due to their beliefs that once someone is dead it is disrespectful to interfere with their body: "I sometimes question ... are we doing the right thing cutting someone up after their death ... like are we doing the right thing" (P21).

In the literature, this aspect was congruent with the current study's findings. The findings by Sanner (2006) in her study examining people's attitudes and reactions to organ donation also identified that people held views that the deceased body should rest in peace and therefore making incisions on the dead body was reported as disrespectful. Boey's (2002) study on Hong Kong nurses also emphasised similar fears toward "body mutilation" and "body integrity" of donors (p. 102). Looking further in the medical literature this aspect was also identified within the research study by Skinner (2010) on first year medical student's experiences of cadaver dissections who also referred to the body as sacred. A participant in their study also emphasised "... It's a very sacred opportunity to be able to dissect ..." (p. 74). Similarly, another study by Hancock, Williams, Taylor and Dawson (2004) of 110 medical students experiences of their first dissection from a New Zealand medical school also identified that dealing with death and dissecting cadavers was outside of their normal experiences however they attempted to dissociate from their experiences: "I haven't found it affected me all that much- you pretend it's not actually a person if it's getting difficult" (p. 23).

In the current study, due to the procurement process participants had to constantly remind themselves that they were operating on a patient who was a cadaver donor: "Well it's the whole thing [the situation] the patient is brain dead but the heart is still beating and everything. It's like that sign of body death" (P19). One participant constantly found the need to reflect that this patient was a cadaver donor:

I mean, I kept reminding myself that this patient is deceased. It's not exactly the most attractive type of operation because the patient is sort of slit from head to toe ... there's millions of people waiting to get their share of their organs. So it was ... all fairly full on [the activity surrounding the surgical procedure] and there is a million people [procurement teams] in the theatre

sort of tripping all over each other and big eskies and it was chaotic and initially so. (P19)

During the multi-organ surgical procedure there is an urgent need to recover organs from the cadaver donor quickly and participants voiced concerns about the hurried nature of the surgery claiming that it was unlike any other operation they had participated in: “There was no finesse about it either [the surgical procedure]. It was just basically get in there get these organs [out] we need to get them out, as soon as possible because somebody [a recipient] is waiting to receive them” (P13). The very large surgical incision made on the cadaver donor to retrieve the organs was also a cause of concern as participants had not previously witnessed these larger types of incisions during routine surgical procedures: “It was kind of shocking it was ... very blunt. I don’t know what the word to use to describe it I don’t think it was butchery because it wasn’t but it was very basic” (P13). Another participant provided a different perspective:

I was looking at this huge incision it was from up here [motioning to chest] to ... the pubis. It’s just so huge and the way the retractors are put in the chest and the chest is retracted it’s like ‘oh’ and it’s like ‘wow’ everything is opened so wide because normal surgery you don’t have that kind of retraction. (P14)

A similar perception was provided by another participant:

Once flat line occurred ... the scalpel was in from side to side there was no nicety about it ... no sort of ... haemostating [stopping bleeding by clamping vessels] this off or diathermying [use of electric current to stop bleeding]. It was just slash in, let’s get the kidneys out and it just seemed to be a bit of a rush but again I keep reiterating it’s for obvious reasons they need to get moving [get the organs out quickly]. (P17)

In addition, the closure of the surgical incision made on the cadaver donor was also a concern for participants as it was not done with the same care and precision that was normally afforded to a patient following a standard surgical procedure. One participant emphasised the overriding importance of getting the organs off to waiting recipients as being the principle focus of the team rather than making a neat, precise and cosmetic skin closure:

There was no finesse in closing the [donor] patient. It was almost like they [the procurement surgeons] weren’t really bothered about their closing [of] the wound ... they weren’t looking for a cosmetic end result their primary focus here isn’t making a beautiful skin wound its actually to get these organs back to where they need to be for this person. At the end of the day does it really matter because that wound is covered with a dressing? (P13)

Within the literature, a similar experience was provided by a participant in the study conducted by Wang and Lin (2009) who stated: “After taking away what they needed, nobody cared whether the wound was still opened and just walked away” (p. 280).

Moreover, in the current study, participants also explained that the procurement of the cadaver donor's eyes was particularly distressing for them as this was external to the body, more visible and could not be covered up. A participant provided the following impact of this experience:

I recall the eyes, the nurse coming in and taking his [the donors] eyes out ... an enucleation [the surgical procedure term for removal of an eye] and I was just like yeah [stunned] and then she put ... an artificial eye in and I just thought it was just really awful to do something like that to a human being. (P21)

Moreover, several participants disclosed that the donation of eyes brought home the fact that they were *operating on a cadaver donor* which personalised the event as they were exposed to the face of the donor:

You associate the eyes with the face [of the] person. Whereas with a lot of other surgery because you can cordon it off and you're just seeing this one area ... I keep going back to compartmentalising ... You sort of don't associate it with a person ... you are just doing this work and then you take the drapes off and ... there's a person underneath. (P34)

Therefore, this aspect of the procurement procedure was reported as quite distracting for the participants as they were not only confronted with *operating on a cadaver donor* but having to witness such events. One participant explained that she could not bear to witness this event prior to the procurement procedure and requested that this take place later:

Once, I did, one retrieval where they actually removed the eyes before we started which I had a big problem with and I actually went to the head [of the donor] and I said to the doctor "I can't do it [participate in the procurement surgical procedure] if they do that ... removing the eyes when the heart is still beating. It really gives me the chills so [I'd prefer] the eyes not to be removed until the end ... till after the completion of the multi-organ procurement procedure. (P23)

Further, another participant spoke of the hardship she faced when having to provide post mortem care to the donor after the removal of eyes: "Taking eyes was probably [the] hardest, that was the last thing they were doing ... they popped in the spheres and then sutured his eyes shut ... [it was] a bit difficult trying to stop them [eye sockets] from oozing and leaking ... for the [family] viewing [the body] afterwards" (P28).

3.3.3 The grieving family

The third aspect of *being unprepared* was when participants came in contact with *the grieving family*. *The grieving family* was comprised of three components: 1) *exposure to family*; 2) *witnessing family grief* and 3) *stepping into the family's role by default*. Perioperative nurses explained that they were not used to communicating with and supporting grieving donor family members in the theatre environment or witnessing their open display of grief. Similarly participants also felt unprepared and out of their depth when in certain situations they had to step into the family's role in their absence.

3.3.3.1 Exposure to family

The first component of *the grieving family* was articulated by participants as having *exposure to family members* of donor patient's prior to the procurement procedure. Perioperative nurses generally have limited *exposure to family* as a result of working behind the closed doors of the operating room. This limited their opportunity of being exposed to the families of patients they were caring for in the operating theatre: "As perioperative nurses, we would not have anything to do with the relatives, ever" (P4). However, on rare occasions contact with a patients' family does occur within the operating room environment. Participants reported three examples of this, such as when a young patient is accompanied by their parent to theatre; when the family attends to see their loved one prior to or after a procurement procedure and on the sad occasion when a patient dies unexpectedly on the operating table during an operation: "If we've had a death in the theatre we've had family come into theatre" (P9).

As a result of having minimal contact and exposure to the family of patients many perioperative nurses do not get an opportunity to develop the skill set to work with families, particularly those who may be experiencing a crisis or stress as one participant commented:

We're actually, quite isolated [in the operating room] ... quite protected in here as far as the emotional upheaval and things that families go through within this period of time [requesting organ donation] ... normally the families are in ICU ... waiting [for the donor to die]. I think in some ways we are very protected from families here [in the operating room]. (P34)

However, *exposure to family* did occur prior to, during and post an organ procurement procedure and participants expressed finding these encounters difficult: "I don't like [seeing] anybody crying [witnessing the donor family's grief]. I can't stand it. I really have a thing about grief [nervous laugh], about seeing people grieve" (P4). Similarly, participants in the regional and rural areas reported that they often had *exposure to family* usually at the entrance doors of the operating theatre department. During this time they were often preoccupied with preadmission checks of the donor on their arrival to the department. They believed that this was an extremely poor environment for relatives involved in this important life event and felt obligated to make the environment as conducive as possible for all concerned:

Sometimes too, the relatives are with the patient [the organ donor] and that's where they sort of say their last goodbyes. It's at the front doors of the theatre ... you get to witness all of that and you know these people are really upset and distressed and they need comfort and you can't sort of comfort them in a way ... how I'd like to [comfort the family] ... I've got to worry about my instruments or getting theatre ready and the job that's at hand when the patient comes down. (P25)

In this study, perioperative nurses worked with two different types of donors; brain dead and DCD donors and they had to accommodate two different levels of exposure to donor

families. For example, exposure to families of brain dead donors predominantly occurred after the procurement procedure was completed as the family members of brain dead donors had an opportunity to say their goodbyes to their loved one in the ward setting for several hours prior to the organ procurement procedure. However, sometimes these families also requested to see their loved one immediately after the donation procedure while they were still in the operating room setting and it was on these occasions that participants had contact with these families. Following these visits the cadaver donor is then sent to the mortuary where again the family may have yet another opportunity to view the body again.

Participants reported having greater exposure to the families of DCD donors and having to communicate and support these grieving families in the theatre environment at the various hospital sites. The presence of the family within the theatre environment during the time of the donor's death provided additional responsibility for the perioperative nurse in caring for their needs, which were reported as extremely difficult and stressful situations. As well as caring for these family members the nurses had additional pressures related to preparing themselves for the technical aspects of their role during the procurement process. They reported that their interactions with families impacted on their ability to prepare themselves for their participation in the procurement procedure. One participant validated this aspect by reporting: "I don't think ... I'd be able to handle things, there is no way I could cope with a grieving family and then come into theatre and do a job, I couldn't handle that!" (P4).

Some participants voiced their concerns of being exposed to DCD donors' families to their line managers and pleaded with them not to be placed in the situation of being exposed to these families whilst also having the responsibility to assist in the patient's procurement procedure as it was deeply distressing for them: "It's a difficult time to see the grief displayed by families" (P17); "It's hard to witness family who are grieving ... you see their faces ... you have that association" (P25). This concern was further expressed by another participant:

Perioperative nurses, we don't want the family anywhere near us. We have enough trouble dealing with what we're doing to someone [assisting in the procedure] without having to see the mother, the father, the whoever so emotionally distraught it tears us apart. (P29)

They also voiced a preference that families did not have access to the operating theatre and were able to say their goodbyes prior to the DCD donor coming to the operating room:

I know when they started talking about [DCD] at our place [hospital] I was the educator and the organ co-ordinator came down and we were talking about it [DCD donors & multi-organ procurement surgery]. I said you need to talk about [the] different types of donors [brain dead and DCD donor] and [the] procedure. I said if you're asking me personally what I feel. I said don't have the family anywhere near them [perioperative nurses] ... I said you will have to talk to all the other staff. We had quite a few meetings over

the time ... to get feedback and talking to staff and the overriding effect was no family anywhere near us, no family, please. (P29)

Several participants felt that having prior exposure to the family made it very difficult for them to concentrate on the technical aspects of their surgical role throughout the procurement procedure: "I think it would be very hard ... very emotional, it would be a very stressful operation to be involved in" (P18). Having *exposure to family* was therefore of great concern to several participants who obviously felt unprepared for this aspect of their work role. One participant poignantly emphasised this point:

They [management] were even talking about bringing the patient [DCD donor] around and leaving them in the anaesthetic bay with the family to die and then going into the theatres. I said "the staff won't cope with the family". It sounds terrible but we don't cope well with family, I think that's why we're theatre nurses. We don't cope well with all the emotional baggage. We're a bit more clinically inclined, get on with the job. I don't know, that's my little theory. You want the patient asleep so you don't have to talk to them ... Sorry [nervous laugh]. (P29)

Similarly, within the literature these encounters with family were also reported as difficult. In the study by Carter-Gentry & McCurren (2004) exploring the personal challenges of perioperative nurses when participating in organ procurement surgery also identified contact with family as "difficult" and "emotionally taxing" as they themselves got involved in the family's grief (p. 426). A participant from their study disclosed the experience of a mother who came to the operating room with her son and stayed until: "The machines were cut off" (p. 246). Whilst another participant in their study stated: "I will never forget it as long as I live" (p. 426).

3.3.3.2 Witnessing family grief

Witnessing family grief was identified as the second component of *the grieving family* and the larger concept of *being unprepared*. Participants from different hospitals sites spoke of being unprepared when witnessing family grief at the time family came into the operating theatre to be with and witness the death of their loved one who was a DCD donor: "It's ... pretty full on [witnessing DCD donor's death] especially dealing with the family ... seeing the family's grief because it's harder to detach yourself ... when you actually see that [open grief]" (P18). Another participant recounted viewing the family saying their brief and tearful goodbyes at the time of the donor's death through the glass windows of the anaesthetic room which was next door to the operating theatre. The participant stated that viewing the family through the windows whilst waiting for the commencement of the surgical procedure with their already prepared sterile surgical instruments was heartbreaking: "To have the family there [visibly next door] with me standing [in sterile theatre attire] you know instruments poised sort of ready to go. I just [found] that really heartbreaking" (P29).

Several participants who found themselves assisting in the procurement procedures of DCD organ donors reported that these procedures were more intense than other procurement

procedures as the surgical team and family had to wait for the donor's inevitable death. Participants described this aspect of the procedure as difficult and traumatic: "They [the family] are obviously very grieved and it's hard to witness ... their grief without being affected ... and you feel a bit of that grief yourself and sadness even though you don't know the person"(P25). Similarly other participants talked of witnessing the private moments between the family and the donor patient prior to the donor's death difficult to comprehend and come to terms with: "Just the fact that you know most people [family] would probably lean over and touch them [the donor] and kiss them ... you know that they're going to be dead [the donor]" (P26).

Witnessing the final goodbyes of the grieving family during the stand down period of two to five minutes after death was confirmed as further adding to the perioperative nurses' level of distress. They believed that this short time of two to five minutes was not sufficient for a family to say a proper goodbye as it was only at this time that the finality of the situation registered for many family members. One participant described her views on this aspect as: "With the grieving process, where people are with their loved ones [the donor] there's a process where they're letting go and letting go ... in fact it [the stand down period] doesn't allow that letting go process to happen" (P26). Another participant provided the following viewpoint:

It would be awful both for the staff and for the relatives to see this unfold. I know that maybe research is showing they need to be there right till the end. I certainly would not want to see my relative dying in the theatre with everyone [watching]. I think that would be a horrible thing for the relatives and let alone then for staff to watch the family [saying their last goodbyes].I think that will have a big impact on staff proceeding with surgery ... I think the effect would be bad; I'm certainly concerned for the family to witness this and I would find that very difficult and confronting. (P23)

Due to the presence of family and procurement teams, waiting and witnessing the donor's death it was necessary for participants to contain and hide their emotions and for these nurses *hiding behind a mask* continued even after families had said their goodbyes. It is practice that when the goodbyes are completed that family are quickly escorted out of the operating room to allow the procurement procedure to commence immediately. This process was also described by participants as an equally distressing time for them:

I would think if you are involved in taking the family out [escorting them out of the theatre] as you will be talking with them on the way out which is a really hard thing to do and not something that we do a lot of in theatre. Normally [we are] escorting parents out saying "Your son is going to be fine" ... what do you say when someone has just said good bye to someone [a loved one as a DCD organ donor] that they love and know they [have just] ... died ... I think that would be a very hard thing to do. I think that would be very difficult to work in that situation. (P18)

Participants also expressed feeling unprepared following the completion of the procurement procedure when some families requested to see their relative again: "A

couple of times the family have said they want to see the patient post the procurement procedure” (P29). It was during these occasions that participants again experienced hiding *behind a mask* any emotions they were experiencing as a result of *witnessing family grief*. During these times families often wanted another opportunity to say their final goodbyes and to ensure that their loved one wasn’t disfigured in any way as a result of the surgical procedure:

Post operatively they just want to see their family member [the donor], to make sure they are still looking the same ... are they going to have big scars or ... look different ... we try not to disfigure them ... so it’s really just [another opportunity] for them [the family] to say their good bye[s]. (P12)

Participants found these encounters very confronting as they had just completed assisting with the surgical procedure and were still internally debriefing from what they had just experienced within the operating room: “I never know how to ... or what to say to someone who has just lost a family member” (P14). Although the participants acknowledged it was important for the family to see the donor postoperatively this added to their own levels of distress: “I find it very hard to have the family around that is extremely hard for me” (P29). Some participants articulated that it was easier on them if they did not know the family: “I would rather not know the family” (P19); “I’d feel so much empathy for all of them I’d be sitting there crying with them. I just can’t deal with that [seeing the open grief of] the family over the donor” (P29). Some participants reflected on the fact that when speaking to family at this time they were careful not to pay platitudes on the family’s decision to donate their loved ones organs as one participant explained: “I think at that time it is their private moment as well so although you want to, I can’t say it’s good on you to have donated your loved ones organs” (P35).

When having to support *the grieving family* after the procurement procedure, participants related that they were mindful to provide the family with privacy. However, this was often difficult within the operating room environment with no suitable environment for this final visit to occur in a private area. Where possible, participants moved the family to a more private but still unsuitable environment such as the recovery room or the pre admissions area. After hours these areas were often quieter however the family still remained surrounded by perioperative nursing staff and the occasional emergency patient. While curtains were used to provide some level of privacy the families grieving could be heard openly within this environment. One participant provided the following example of this experience:

Depending on the day, that was in recovery because it was late at night but if we did have patients in recovery we have also in the past used the pre admission area [another area within the operating suite] if there is nowhere else ... obviously after hours, there are no patients being admitted [to the recovery area] it’s a quiet area basically. (P12)

The study by Kirchhoff, Spunhler, Walker et al. (2000) investigating the experiences of end of life care by ICU nurses also identified physical barriers such as a lack of “space and

privacy” for families in the ICU environment compromising good end of life care (Kirchhoff et al., 2000, p. 40).

In this current study, the amount of time that grieving families were permitted to spend with their loved one following the procurement process differed as a result of the changing theatre environment. One participant emphasised the need to ensure that the family had all of the time that could possibly be allocated within this environment:

It’s traumatic for any family to go through the loss of a loved one so everything is emotional, you just have to give them time ... two hours and hopefully there are no other patients [in the recovery room], you let them sit there ... otherwise they are going to feel as though they got shoved out [of the operating room] ... or [say] “I didn’t have enough time to say my goodbyes”... usually they’re young [donors who were previously] healthy , most of them are sort of young people in their 20’s. (P34)

Participants also spoke about witnessing *the grieving family* who were often seen congregating outside of the operating room department in corridors or other adjoining areas of the hospital before or after the procurement surgical procedure. As these relatives were visibly distressed, this impacted on the well-being of participants who could relate to the grief the family were experiencing:

What does upset me is the relatives that are standing around outside theatre ... Often in tears and I find that actually more upsetting than dealing with the patient [the donor] ... witnessing the open grief ... there is usually a lot of relatives particularly with young patients; it’s not just the family you get all the friends ... I actually find that quite upsetting ... to walk the gauntlet of the grieving relatives. (P4)

A similar sentiment was expressed by another study participant who described the helpless situation where nothing could be done to relieve the grief the family were experiencing:

I find ... it was upsetting when I thought of the family ... because ... there’s nothing you can do to change what has happened to the donor and I think most people that I worked with certainly give more of a thought for the family’s grief. (P23)

3.3.3.3 Stepping into the family’s role by default

The third component of *the grieving family* experienced by perioperative nurses was stepping *into the family’s role by default*. For the participants in this study this occurred when family decided for whatever reason to not be with their loved one at the time of a DCD donor’s death. As a result the nurse had to remain with the patient and several participants expressed feeling distressed at having to take on this role often at short notice: “It should be the family at their side ... it was difficult ... this was not my relative ... they were so alone at the time of their death” (P30); “I felt like I’d failed the donor ... I was not family ... I could not give them a proper goodbye they were not my relative [referring to

giving them a kiss or hug]" (P35). Likewise another participant reported a situation where the family decided not to escort the donor to the theatre to be with them at the time of their death as a DCD donor: "For whatever reason ... they chose not to be there ... it's hard to understand why you would leave a relative alone during this moment no matter how difficult [an emotional time] it is" (P32).

Another participant recounted that she was involved in a DCD procedure where the patient was a young man in his twenties and his family did not come into the operating theatre. She felt upset that the donor was left to die alone amongst strangers with no family at his side at the time of his death: "It's a little bit odd, the family didn't [come inside the theatre], the family said their goodbyes [to the DCD donor] the night beforehand so they didn't come at all that morning to the operating room" (P31). Although participants in these situations questioned why the family had not accompanied the person to say their final goodbye, they were also at the same time relieved that they didn't have to interact with the distressed family: "I don't think the patient's relatives wanted to see her [the donor] afterwards which was a good thing for me, 'cause they said their goodbyes in ICU before she came through to us" (P24).

Similarly, other participants were also affected when the family did not see their loved one following the procurement procedure. The decision to view the body post procurement was often dependent on what organs had been donated and the state of the body: "Depending on how much is taken [which organs] quite possibly they [family] won't get to see them again, they may or may not" (P26). Other participants felt overwhelmed with their own grief when it was recommended that the family could not view their loved one after the procurement procedure when they had been disfigured as a result of their accident injuries. One participant described such an experience: "The patient ... died a traumatic death ... [he] was 16 [years old] ... he shot himself in the head and ... basically [he] had a garbage bag sitting on his head [during the procurement procedure]" (P19). On these occasions, participants felt that they were *stepping into the family's role by default* to perform a next of kin role as opposed to their health professional role. These participants were saddened that these donors were alone at a time when they should be surrounded by their family. Several participants in these circumstances felt unprepared for this role and the additional grief they experienced by becoming connected with the donor in the absence of their family.

Within the literature, a similar experience of this was reported in the study by Pessagno (2010) when a participant also provided a similar example of staying with a patient at the time of their impending death in the absence of family:

".... I spent my entire shift with her there because she had no family there and I did not want this woman to die alone... I didn't want to do it. But I really felt that I needed to stay there until she died. And so that's what I did" (p. 48).

In summary, *being unprepared* was reported as the first stage of the basic social psychological problem of *hiding behind a mask*. In this stage, participants felt unprepared when *being confronted to participate* in a procurement procedure which predisposed them to *not knowing what to expect* as a result of undertaking these procedures with external procurement surgical team members. They were also unprepared for *being exposed to death* when *operating on cadaver organ donors* and similarly dealing with *the grieving family* members of multi-organ donors within the operating room environment. As participants moved into the second stage of the basic social psychological problem of *hiding behind a mask* which was titled *being overwhelmed*, their need to *hide behind a mask* further intensified.

3.4 Stage 2: Being overwhelmed

The second stage of the basic social psychological problem of *hiding behind a mask* was conceptualised as *being overwhelmed*. Three aspects of *being overwhelmed* were identified: 1) *fears of facilitating death* 2) *the graphic nature of the procurement process* and 3) *emotional experiences* (See Figure 3.3).



Figure 3.3: The aspects and components of being overwhelmed

Participants within this study described *being overwhelmed* for several reasons. Firstly, they feared that they could have facilitated the death of the donor whilst assisting in the procedure. Secondly, they were also overwhelmed at having to witness the *graphic nature of the procurement process*. Thirdly, participants found it difficult to come to terms with the negative outcomes of the procedure as the donor was no longer a whole person but an organ-less body. Participants were overwhelmed when they were present and experienced the death of the donor: “With the multi organ [procedure] ... you’re there, you’re part of that you’re assisting with taking his life, that patient’s life away even though they’re dead” (P21). The experience encapsulated participants *being overwhelmed* by their own *emotional responses* to the donor’s death by having to hide and contain emotions and feelings from work colleagues. The *emotional experiences* by all the participants were varied in intensity and duration with some *being overwhelmed* by the effects of

“flashbacks” or reliving the experience of the procurement process a long time after the procedure had occurred.

3.4.1 *Fears of facilitating death*

The first aspect of *being overwhelmed* was identified as *fears of facilitating death*. Participants in this study reported feelings of *being overwhelmed* with *fears of facilitating the death* of the donor as a result of their participating in multi-organ procurement surgical procedures. These fears stemmed from their doubts about whether the donor was in fact really dead at the time of having their organs procured. One participant explained these fears and doubts as:

I think it's because of what we see. I think in the back of our minds ... I think is that patient really dead ... I guess that's the worry. Are they really [dead] ... I think that is [a] genuine fear ... that's probably a genuine fear with everyone but I think it's more because of what we do and what we've done. (P30)

Another participant provided a similar account:

I always struggle with doing them [multi-organ procurement procedures]. I find it hard to think and believe that the person is actually dead. There's always that query in the back of my mind and I know that there is the testing that ICU and all the doctors have to do before they're pronounced dead, clinically dead but sometimes there is just always that niggling thought in the back of my mind, is this person really, could they be wrong and then if so what we're doing are we, well we're killing this person and I struggle [with this], at first I used to struggle with that, I still do to a degree but probably not as much. (P25)

These fears and doubts occurred as a result of brain death testing being done prior to the donor coming to the operating theatre, for example when tests were undertaken in the intensive care unit. Therefore participants were not present and did not witness the testing to confirm that the person was in fact brain dead. In addition, several participants reported not fully understanding the procedures involved in determining brain death. This lack of understanding perpetuated a fear that the donor may not really be dead when they had had their organs procured. Therefore, participants were overwhelmed by the fact that they may have facilitated the death of the donor: “A certain amount [fear] for myself, a certain amount of fear and like I said before fear of ... is this person really deceased” (P25). Although participants described that they had seen the paperwork evidence of the testing they still had doubts but hid these doubts from other members of the surgical team: “At the time when you're looking at the paperwork ... you look at the [donor] identification, the doctors have declared this patient brain dead and you sort of look at the paperwork going, yep, yep, yep [agreeing, however you still have doubts]” (P27). Another participant expressed uncertainty and a different viewpoint by expressing the following:

I think they probably are brain dead and I think they probably haven't got a future but I just, they are alive and ... they have a life force, that if hitched into the primitive brainstem and [are] keeping the heart beating and I just can't equate stopping that and not acknowledging that we are actually killing the patient. (P26)

For participants who had never experienced caring for a brain dead donor these experiences intensified:

When I did my first multi organ procurement ... I can remember actually feeling quite horrified [nervous laugh] at the whole thing and it was very hard to get your head around the fact that the patient was actually brain dead. (P19)

Within the literature doubts about the concept of brain death and whether donors were in fact dead has also been identified widely by other authors (Floden & Forsberg, 2009; Sadala, Lorencon, Cercal & Schelp, 2006; Vritis & Nicely, 1993; White, 2003; Youngner, Landefeld, Coulton, Leary & Juknialis, 1989). Earlier research studies also identified doubts amongst health professional in brain death diagnosis and criteria. The earlier study by Youngner et al. (1989) of 195 health professionals consisting of physicians and ICU nurses noted that as health professional they too did not believe that brain dead patients were in fact dead. Another earlier study by Vritis and Nicely (1993) of 1, 416 nurses practicing in the ICU, critical care and the operating room also identified a lack of knowledge about brain death criteria.

More recently, the study by White (2003) investigating the ICU nurses perception of brain death also found that 48% of these nurses demonstrated ambivalence by referring to brain dead donors as "near dead or incompletely" dead (p. 12). The recent research study by Floden and Forsberg's (2009) study of ICU nurses also emphasised a lacked of understanding about brain death. One participant in their study provided this insight: "Perhaps not even I myself have fully grasped the concept of brain death" (p. 309). Further to these findings, Sadala's et al. (2006) phenomenological study on Brazilian ICU physicians views of caring for organ donors also identified doubts and insecurities amongst these health professionals in defining brain death and the effectiveness of the examination: "I am afraid of some brain death diagnoses [sic] because not everybody uses the criteria that we use here ... and many criteria we use here are still being discussed" (p. 195).

Within this current study, despite these concerns other participants reported that they had to have faith in the test results of the donor's status of brain death: "They've had the testing done and you know like there is no activity of life" (P16). Other participants also commented that although experiencing initial doubts that they had to come to terms with this aspect. One participant provided this description: "Initially I had doubts in my first [procurement] procedure, that I did, but I'm more than confident in that the controls that are put in place for determining brain death, I'm trusting of those" (P33).

Participants in this study also feared that they were facilitating the death of the donor as when donors arrived in the theatre they often looked relatively fit and healthy, visibly alive and warm to touch like any other unconscious patient that comes to the operating theatre: “The patient comes to us, they’re pronounced dead but I find it hard to view them as being deceased” (P25). Another participant provided this account:

I just felt that here we are, we are now going to take this [donor] patients organs. He’s clinically dead but they come down [to theatre] breathing they are still warm, they are still for all intentions and purposes alive ... in actual fact and diagnosed to be clinically dead. It was just you know various emotions sort of going around at the same time like here we are going to do this thing [the procurement surgical procedure] to a generally [fit and healthy], it was a young person [donor]. (P20)

Other participants also reported finding it difficult to come to terms with the brain death diagnosis of various donors who came to theatre with no visible injuries or marks on their body from traumatic injuries that had caused their death. One participant recalled the following experience: “I was assisting in a multi-organ procurement procedure ... a young child, a girl ... [there was] not a mark on her and she had been in a horse riding accident” (P10).

This aspect was also congruent with the findings of Pearson, Robertson-Malt, Walsh and Fitzgerald (2001) who indicated that intensive care unit nurses constantly needed to clarify the diagnosis of brain death to the family as to family members, often their loved one still looked so alive. One participant from Pearson et al. (2001) ICU study described the ambiguity of donors looking alive but being diagnosed as brain dead:

They [the donor] can look perfect, that’s what just blows the family away, I’m sure, sometimes. You know, how can they be, how can you tell me that’s what is happening inside their head when, you know, he hasn’t got a scratch on him, type of thing. (p. 137)

In this study, participants also described experiencing doubts and *fears of facilitating the death* of the donor at the moment the first incision was made to commence the procurement of organs. One participant recounted the following experience of having these doubts:

There were times when you thought that possibly you know that this is a live person [the donor] that we are going through, going into [making incisions] but once you get past that and once you start [the procedure] you are so concentrating on the procedure that the impact of what you are doing from a humane point of view possibly ... doesn’t really come into it, doesn’t hit you till much later. (P8)

Moreover the same participant described ongoing feelings of doubt and guilt after the procedure that she may have facilitated the death of the donor:

At certain times I do ... I have struggled with guilt ... well struggling with, like I said feeling guilty that this person is actually deceased but are they really ... and when I'm assisting and participating with the procurement [long pause] is that adding to this person's dilemma of death? ... I don't know how else to sort of describe it ... it's like a dilemma. (P25)

Throughout the procurement procedure while assisting the surgeon several of the participants continued to be overwhelmed with uncertainty and fear that they may be facilitating the death of the donor:

No I think it's just an uncertainty that you feel yourself, you know that you think and you always think God I hope this patient is [dead]. I hope it's not something that in 20 years they discover and go wait a minute. You know maybe those patients weren't dead. There's that sort of a feeling. (P30)

3.4.2 The graphic nature of the procurement process

The graphic nature of the procurement process was identified as the second aspect of *being overwhelmed*. Perioperative nurses are thought of as being able to cope with whatever happens within the operating room. In reality, organ procurement surgery really affected them at an emotional level due to the very graphic nature of what they experienced during the procedure: "[It is] very confronting [seeing the donor and the surgical procedure] all-round [the whole procurement process from start to finish]" (P30). Other participants gave these descriptions of seeing the operation: "I didn't expect that [seeing the donor opened up and having all the organs removed] ... a little bit shocked" (P12); "I really felt a little bit lost [during stages of the procedure] I felt it was really quite overwhelming" (P15). For some participants, it was the closeness and the visual impact of the procedure that was most overwhelming for them: "It was ... more the visual impact for me that's what I found hard like this person [the donor patient] open from here to here [motioning with hands the incision site from sternum to pubis]" (P19).

Although many participants provided similar descriptions of *being overwhelmed* at what they were seeing, others were so distressed they were lost for words to fully describe the scenes of the procedure they were participating in: "The only word I use to describe them is horrific" (P29); "I think it's a little bit macabre" (P4); "Goriness" (P26); "It's still gruesome" (P30); "It is very graphic ... it is graphic because you can actually picture [see] it" (P30) and "[It is] quite graphic even more so for perioperative nurses because we see a lot of this [procurement surgery due to assisting] ... it can be quite graphic and sort of butcher like" (P33). One participant who was particularly overwhelmed by what she had witnessed referred to the procedure as body snatching: "It's a bit gruesome, you know body snatching type of thing, I shouldn't say that but it's true" (P30).

Apart from *being overwhelmed by the graphic nature of the procurement process* participants were also overwhelmed that they too were participating in this experience which was described as a brutal and barbaric procedure that was happening before them: "It [the procedure] was sort of brutal the only way I could describe it, it was barbaric in a

way, what you are doing taking [the organs] out of this [the donor's] body" (P19). Another participant gave this account:

I felt, it felt a bit strange to have done that [assisting in the procurement procedure] to her [the donor], to have taken these things [organs] away from her. That was a bit, I felt a bit sad in a way. I don't know if I felt guilty or something but I just didn't, it wasn't particularly comfortable even though I knew that she [the donor] was dead, that she was brain dead, it just seemed a very negative result. When you're a theatre nurse for 20 years, you're trying to fix things up whereas you're just basically taking everything away from this person. (P24)

Within the literature a similar description about the procurement surgical procedure was also described in the study by Carter-Gentry and McCurren (2004) by a participant who described the procedure as: "barbaric" leaving her "cold and empty inside" (p. 427).

In this current study, throughout the procedure, several participants' reported experiencing high levels of stress due to *being overwhelmed* by their participation and what they were doing: "Because it [assisting in the procedure] is not a comfortable thing to do anyway ... and it shouldn't really be comfortable ... I feel, it's really weird if you feel comfortable doing that [participating] ... you shouldn't be comfortable" (P32). Other participants provided these graphic descriptions: "It is pretty hideous opening up someone, taking out all their organs" (P30); "With organ retrieval like you [are] taking all the body parts that you would require [when alive] and then you're left with an empty cavity" (P27).

Participants provided graphic descriptions of the procurement process and the difficulties experienced when procuring certain types of organs and bones at the time of their participation. One participant recounted her experience when procuring long bones such as the femur or tibia from a donor:

I remember they had one [donor's procedure] ... where they had done the [long] bones and I remember they were asking for brooms, broom sticks and I thought oh my god [nervous laugh] that would freak me out a little bit, it was just the thought the whole thought of it [the procedure]. (P19)

For another participant it was the surgical positioning of the donor patient on the operating table that overwhelmed her: "Even the positioning of the patient, you know their arms above their heads like being stretched out on their back" (P30). The length of experience as a perioperative nurse did not make witnessing these events any less traumatic for the nurse. This point was exemplified by one participant with extensive experience in the perioperative nursing field: "I would probably say that for somebody who has been in theatre all my life, I did find it very challenging to see what happened [during the multi-organ procurement procedure] in the theatre" (P26). Other participants provided similar experiences: "I was like this is just gross [the surgical procedure], the fact that the patient literally exsanguinates [to be drained of blood] on the table in front of you and it's brutal" (P19); "I think it's still confronting, I do. I think it's still gruesome" (P30).

3.4.2.1 *Role conflict towards the procurement procedure*

A component of the *graphic nature of the procurement process* was identified as the participants own internal *role conflict towards the procurement procedure*. Several participants experienced *being overwhelmed* by their professional *role conflict towards the procurement procedure* which was articulated by participants as not a life saving procedure for the donor patient who was before them: “There is a loss of life” (P21); “There is that loss [of a life] ... with the procurement there is a sense of failure, failure in healing the person or promoting healing” (P25). Several participants found it difficult to come to terms with the loss of the donor’s life and were left feeling helpless: “The patient’s dead, they are not going to recover” (P29). “Usually we save people” (P31); “We’re here to cure” (P29); “You’re trying to fix things up [when you usually participate in surgery]” (P24). Participants found it difficult processing the loss of life before them as being a perioperative nurse was usually viewed as a fulfilling role, working towards positive outcomes for patients after their surgery. Participants were used to saving lives and making significant differences to people they worked with on a daily basis. This was articulated by one participant as: “Surgery that is more productive” (P33).

In the operating theatre environment surgical procedures are often viewed as either curative, diagnostic or for palliation purposes. However, multi-organ procurement surgery does not fit into a particular operative category as one participant reported:

I do a lot of teaching or I do a lot of mentoring with students. I always say there are three aspects of theatre ... and I always try and bring it back to basics. The main role of the theatre nurse is curative and we cure, the majority of our patients come in that door [referring to the operating theatre doors] ... to be cured, the second one is diagnostics and then the next one is palliation. A [multi-organ] procurement [procedure] doesn’t even fit into any of those sorts of little holes [referring to surgery categories] ... I find it difficult ... but it comes back to what I was saying before, the majority of our patients we’re here to cure ... one of those three categories. (P29)

Participants conceptualised that organ procurement procedures were not performed for curative, diagnostic or for palliation purposes as they did not benefit the donor and this added to their feelings of being overwhelmed. The same participant emphasised: “It’s outside of normal and to me it’s outside my normal range” (P29). The participant went on to provide more detail of this situation:

You know the [donor] patient’s dead, they are not going to recover, you know all that but even still when you, come in and take the organs and then you actually turn the machines off ... I find it very hard to describe; I just find it very upsetting. (P29)

3.4.3 Emotional experiences

Emotional experiences were the third aspect of participants *being overwhelmed* as a result of participating in a procurement surgical procedure. Two components of *emotional experiences* were identified: 1) *emotional responses* and 2) *experiencing nightmares and flashbacks*. Several participants who were overwhelmed displayed an array of emotional responses as a result of assisting in procurement surgical procedures whilst *hiding behind a mask*. For some, their emotional experiences were extreme and they experienced nightmares and flashbacks.

3.4.3.1 Emotional responses

Emotional responses were identified as the first component of *emotional experiences*. Participants reported significant *emotional responses* which ranged in intensity and duration leaving them feeling traumatised by participating in and experiencing the surgical procedure: “Just an assault on the senses ... I just wanted to sit in the corner [of the theatre] and cry, it was just disgraceful [referring to what was being done to the donor’s body]” (P29).

Their responses to the situation added to participants’ feelings of *being overwhelmed* and some of them found it hard to articulate these feelings: “It’s really sort of hard to describe [my feelings] because it was just sort of a really, really bizarre feeling” (P11). However the majority of participants reported *emotional responses* such as feeling: “stressed” (P25); “feeling upset” (P9); “distressed” (P10); “revolted” (P1); “turned off” (P26); “anxious” (P25) and “shocked” (P12). Others participants reported: “feeling strange” (P16); “your heart sinks” (P2); “depressed” (P2) and “angry” (P29). They also exhibited emotional responses such as “sadness” (P20; P14; P22) and “crying” (P24; P25). A few participants also reported responses such as “giggles and shock” (P18). One went on to elaborate: “I get the giggles ... it is probably hysteria more than anything ... the way I’m laughing is infectious ... it’s not a disrespectful thing it’s just something that’s happened and a way of dealing with it [aspects of participation] I suppose” (P18). Often these responses, such as giggling, were not well received by colleagues even when the nurse spoke of stress being the cause for their behaviour. The *emotional responses* to their participation took a toll on participants both physically and emotionally with some reporting feeling: “Sick and [feeling] nauseous” (P10) or “break[ing] out in a sweat” (P29). Participation in these procedures was also reported as tiring, intense and exhausting: “You feel exhausted” (P21).

Within the literature, nurses and health professional involved in caring for organ donors within the specialties of ICU, the operating room and critical care areas have reported this work as “emotionally exhausting” (Carter – Gentry & McCurren, 2004; Duke, 1998; Hibbert, 1995; Kim et al., 2004a; Regehr et al., 2004). Similarly, a participant in the study by Regehr et al. (2004) explained that these procedures were reported as exhausting, stating: “When I go home after a night like that, I’m drained, physically and mentally” (p. 433).

In this current study, a feeling of sadness was a common emotion expressed by participants: “Most of the time it’s just sort of it’s just a feeling of sadness ... most of its sadness, sadness from the donor’s point of view [the situation of their death]” (P14). Similarly, another participant stated:

Sad ... but not depressed sad, you know it was a sad thing the donor’s death and having to undergo the procurement surgical procedure] ... yes and just sad for the sort of the whole situation ... but I wasn’t, didn’t feel depressed or didn’t dwell on it or anything, but it was sad. It is very sad. (P2)

The emotion of sadness was particularly linked to the age of the donor and participants found it really hard when the donors were children or adolescents: “The sadness that he [the donor] was so young as well” (P22). Furthermore they expressed sadness about their role in assisting to remove the organs from the donor’s body.

Furthermore, the participants expressed a range of other emotions which continued well after the procedure such as feeling angry or anxious and experiencing conflicting thoughts. One participant reported feeling angry, experiencing emotional turmoil and conflict:

I feel angry occasionally ... I do feel angry ... I still find it a bit difficult ... emotional baggage ... The emotional baggage I carry in, with it you know. When I’m here I’ve got one side I’m saying yippee we’ve got some organs and on the other I’m thinking oh shit I’m not going to sleep for a week now, ... for what I’ve had to do [participate in the procedure] and probably for the person [the donor] too ... for being in there. (P29)

At times participants struggled to cope with their *emotional responses* as to what was happening and openly cried during the procedure: “An awkwardness in how to cope but that was before ... sometimes I’ve cried, while it’s happened, while we’re there, while I’ve actually scrubbed” (P25). Overall, several participants stated that they contained their feelings whilst *hiding behind a mask* however by the end of the surgical procedure many participants could no longer contain their *emotional responses* and broke down at the completion of the procedure: “My feelings were obviously a bit anxious because I had never experienced that before, towards the end [of the surgical procedure] I felt a bit relieved ... I had a bit of a cry” (P24).

Participants also experienced other *emotional responses* which manifested as various physiological effects such as breaking out in a sweat, feeling extremely anxious or physically feeling sick or nauseous during the procedure. Hagan (1997) a perioperative nurse spoke of her experience of feeling extremely sick when participating in a procurement procedure by stating:

Immediately, I felt sick ... I have never felt sick in the O.R., but this case has gone deep into my souls, where innocence has ended. There is a cloud, black and menacing, that hangs over my gentle spirit. I don’t know how to free myself of it or where to put it (Hagan, 1997, p. 31-32).

In this current study, several participants found this a problem as they could not easily hide these reactions and behaviours. Some participants tried to justify these emotional responses as appropriate or necessary to get the job done. One participant justified these increased levels of anxiety as a positive aspect that would ensure that they were able to get the job done:

I'd break out in a sweat before I would walk in to the theatre. I'd be almost throwing up, I always tell people it's nice to be anxious before you do a procedure otherwise you're not doing your job but that level of anxiety was just extreme and it was more the emotional baggage that you take in. (P29)

For other participants their *emotional responses* were more intense during certain stages of the procedure. For one participant, the mere anticipation of experiencing a delay in commencing a procurement procedure on a child donor sparked intense emotions:

Except we had this long wait with the child, and we've always got long waits but long waits cause more sort of thoughts ... I think everyone's thoughts were probably more so with that one than any I think ... playing on your mind more [doubts] ... more conscious of it like usually you sort of say ... you know you've got to do it, I can sort of distance myself from it, with the child I found it more difficult. (P28)

Other participants talked about assisting during the intraoperative stage of the procedure which evoked emotional responses for them. This was highlighted by the following participants' response:

Across the board I felt initially the thing that I didn't enjoy in fact I didn't like at all was ... all the monitoring and then I think the thing that revolted me the most ... turned me off the most probably was the ... perfusion and then you realise everything goes silent [when they switch the monitoring off] that's really quite an eerie sound. (P1)

Several participants spoke of being confronted with *emotional responses* before and after these surgical procedures as they were often so busy focussed on their professional roles intraoperatively. This aspect was validated by the following participant's account:

It was more beforehand [prior to commencing the procedure] that you thought about that [the effects of participation] and then also afterwards ... during the [intraoperative] time you didn't really think of it [what you were participating in and the emotions] as you were trying to keep everyone focused and doing the job at task basically. (P27)

Other participants described feeling upset at the completion of the procedure when their emotions surfaced: "That happens [surface of feelings] probably after the procedure ... I think oh, it makes your heart just sink" (P2). Other participants found the conclusion of the procedure and the finality of the donors death upsetting: "It's a little upsetting ... I get really upset ... I suppose it really hits you then [at the completion of the procurement surgical procedure] what you've just done" (P9).

The range of *emotional responses* were different for each participant regardless of their experience levels within the operating room: “You do [deal with emotional responses when participating] in your own personal kind of way” (P21); “I think if I did one on my day of retirement I’d still feel ... the same as my first one (P29)”. It is important to note that participants stated that they did not openly display their *emotional responses* to others and delayed their emotional responses until they were away from their work colleagues, the working environment and family. This clearly articulates the basic social psychological problem of *hiding behind a mask*. One participant expressed feeling quite upset and described how she hid her emotions till after work by having a cry in the car: “It’s just one of those procedures that I do, I don’t show it during [the surgical procedure] ... I’m driving home in my car is usually the time that I get upset” (P10). A similar account was provided by another participant:

I was actually quite upset when I left after work ... oh I get in my car and have a little cry and then go to bed [laugh] cause normally its 8 o’clock in the morning and you’ve been up since whenever [after working night duty].
(P19)

Some participants were overwhelmed by experiencing stress reactions long after participating in these surgical procedures. They experienced lasting long term effects and were able to remember many fine details of the procedure and the donor as memorable and lasting accounts. These participants were able to recall certain details of the donor, their age, the circumstances surrounding the donors death, the donors family situation, whether they had a spouse, children and close family in attendance in theatre or at the time of their death if a DCD donor, in addition to the surgical procedure itself. These events had a profound and lasting effect on the participants when compared to other surgical procedure they had assisted with. One participant described this experience as: “I find that [participation] in procurement more so because it lingers around with you” (P21).

Within the literature, the profound emotional effects of organ procurement surgery and transplantation surgery were also reflected upon by other health professionals. According to Starzl (1992) in his book *“The puzzle people: Memoirs of a transplant surgeon”* he stated:

The surgeons and physicians also changed-not so rapidly, because their own lives were not at stake, but inexorably, because the lives of others were in their hands. Some were corroded or destroyed by the experience, some were sublimated, and none remained the same..... The secrets are within them, hidden beneath a pile of emotional stones which only they have a right or the knowledge to probe. (p. 4)

In this current study, several participants were affected with intrusive thoughts of donor patients long after their participation experiences: “Yeah, it does affect you, it does ... it is always at the back of your thoughts” (P16) and “You always remember donors, I was sad because you also find out how the patient died and often they are young patients too so that was a bit hard ... you remember these things” (P19). For some participants intrusive thoughts occurred as a result of witnessing the death of the donor:

It stays in my mind because we don't experience death that frequently in the operating theatre ... it is upsetting for a day ... I wouldn't say it's to the extent that you know I would actually be upset and cry but when you experienced any death on a professional basis ... it does stay on your mind. (P15)

Emotional responses with intrusive thoughts were also reported to resurface a couple of days after participation in a procurement procedure:

It's really hard you have mixed emotions and then you think about it a couple of days later and I didn't stop thinking about it on that day [day of procedure] like it was over and done with ... you do think about it for a couple of days but not, like I wasn't morose or it wasn't ... it didn't stop me from functioning or anything like that. (P2)

Similarly, the grounded theory study by Blumenthal (2007) on the experiences of 16 donation coordinators identified that these health professionals also experienced intrusive thoughts which surfaced occasionally: "I've had to put images in my head that will never go away" (p. 15).

In this current study, the effects of their *emotional responses* continued to impact on participants for extended periods of time: "I was traumatised for about 3 weeks" (P26); "I shut down basically. I get very withdrawn for a week or two or a couple of days and then I'll start to pick up again" (P29). Another aspect which played on the minds of participants was their *emotional responses* towards feelings of doubts and questioning whether they had done the right thing by participating. One participant questioned herself after the procedure by the following response:

I didn't have any feelings that we were doing anything wrong ... at the time no, but afterwards yes ... probably did we do the right thing, just questioning what you've done... [whether or not] you have done the right thing in participating ... I mean that's what the [donors] mother had wished for [to donate her loved one's organs]. (P27)

Similar experiences were reported by surgeons who were working within the transplant field. Tilney (2003) reported recalling particular donors, similar to the participants within the current study. In an extract from his book he wrote:

The often tragic memories of individual organ donors remain particularly vivid. Some whose organs I transplanted especially stay in my mind, tempered by acknowledgment of the remarkable sacrifice they made unknowingly and their families made unselfishly and deliberately. I remember grafting a kidney from a young woman who died unexpectedly from a brain hemorrhage, leaving behind her husband and young children. I used an organ from the talented son of a distinguished politician who had been killed by a drunk driver, and that of an elderly male dying after a massive stroke; his kidney, by serendipity, went to his own son waiting on dialysis. Very young donors in particular endure in my consciousness. One boy, playing Tarzan with a rope in a tree, accidentally hanged himself.

Another was strangled in his own garden by his two dogs playing tug-of-war with his scarf. Despite these heart breaking tragedies, and the professional ambivalence that sometimes accompanies them, these donors provide the means that allow others to live. But the ghosts remain. (p. 162-163)

Starzl (1992) also reported recalling memorable patients that he often thought about many years after their death. He wrote about two young girls who he watched play in the park that resembled two young transplant patients he had cared for however had passed away at a young age:

They looked like Stormie Jones and Jody Plute. I had wanted so much to have these girls grow up, but God froze them in time instead. Embarrassed by my sentimental thoughts, I turned away. When the distraction had passed and I looked up again, the distant figures were gone. There is a strange thing about the dimming vision of aging eyes. What cannot be seen clearly, the mind fills in more vividly than reality. (p. 333)

3.4.3.2 *Experiencing nightmares and flashbacks*

Experiencing nightmares and flashbacks was identified as the second component of *emotional experiences*. Participants commonly reported hiding their emotions and reactions during the procedure and they also hid their ongoing lasting reactions such as occurrences of nightmares or flashbacks, memories of the donor, having vivid dreams of the donors, the donor's death or the actual procurement procedure. These participants were able to remember and recall the faces of particular donors within the operating theatre: "... they still have a profound effect on me, I still remember them ... the situation, often I ... recall their faces ... the situation just thinking how awful it was" (P10); "Remembering yes all of it [the procurement procedure], I can see their face, their eyes" (P32). Another participant recounted remembering the face of a young donor and the associated feelings with this memory:

I can remember ... not all of them [donors], one boy in particular he was very young. I can remember him I just can't sort of get used to it [long pause] it is just that they are so cold [the donors' body]. I hate it. (P20)

Having dreams about the donor was also reported by some participants as occurring for several months after a procurement procedure. One participant recounted the following: "I did have dreams about that particular patient [donor] for about two months or three months later down the track. Oh, just seeing him in my dreams all the time. I was sleeping, but when I'd wake up it was just like I'd had another dream of him again ... I couldn't get him out of my head" (P21).

Another participant stated that she was still plagued by nightmares from participation in a multi-organ procurement procedures some 38 years ago on a child donor by the following account: "I try not to look at the person too much to be honest ... I still have nightmares from a child in *[Location] and that was in '74 or '75 [year 1974 or 1975]. I still have nightmares from that one" (P29).

This aspect was similarly reported in the literature by Kent (2004) in a study which looked at nurse's willingness to discuss post mortem donation with families. It was described by one nurse in this study that the consequences of participating in the donation process included feeling emotionally drained, and having difficulty sleeping because of re running the experience in his mind (Kent, 2004, p. 276). This aspect was similarly congruent with the findings from the study by Regehr et al. (2004) who explored 14 operating room nurses experiences and attitudes of working with organ donors. These authors also reported that the participants in their study thought of the donor patient prior to going to bed. A participant from their study provided the following response to this aspect: "But before I go to sleep, I am thinking of the patient most of the time" (Regehr et al., 2004, p. 433).

In this current study, some participants reported replaying intrusive thoughts for a few weeks after participation in a procedure: "I remember that child probably more than anybody [other donors] but it's not that it's worrying to me but it [the donor] will come to mind. I mean I'll never forget that one" (P28). Another participant talked about recalling a procedure and the donor during the evenings at home: "You do ... you replay it back in your mind but that was only for a couple ... of weeks but then like it wasn't every night it was just something that you just thought about"(P27). This aspect was supported in the literature by the findings of an earlier study by Wolf (1991) who also noted that nurses providing post mortem care of donors found it difficult to forget the event for a few days afterwards. These nurses specifically reported remembering the donor and the post mortem care provided (p. 84).

Research on the traumatic experiences of emergency workers and health professionals also have reported similar findings within the literature (Alexander & Klein, 2001; Karlsson & Christianson, 2003; van der Ploeg, Dorresteyn & Kleber, 2003; Winwood & Lushington, 2006). According to Karlsson and Christianson (2003) who undertook a phenomenology study on the traumatic experiences of police work also identified that deaths were traumatic events that impacted on these professionals with experiences such as recalling the events: "... That night at home, I can't sleep a wink. Can't forget the dead child. See it in front of me. Remember the house, the room, and different people's reaction to it all" (p. 424). The study by Alexander and Klein (2001) on ambulance personnel also reported these professionals experiencing distressing events with effects such as recalling events extending from a few days to months following an incident. Similarly, studies on the effects of nursing work also assert that stressful work incidents can impact beyond the work environment (Hall, 2004; Winwood & Lushington, 2006). The Australian study by Winwood and Lushington (2006) also asserts that "psychological strains spill over into non-work time to affect sleep and reduce recovery from antecedent end-of-work stress/fatigue" (p. 686).

In this current study *experiencing nightmares and flashbacks* was troublesome for some of the participants affected by this aspect. Some of these participants further elaborated that the memory and sight of the donor triggered off memories and flashbacks in addition to sensory stimuli such as certain smells. One participant recalled the smell of cutting the donors flesh:

It goes through your mind or something will remind you ... cutting the skin will remind you. You know just little things remind you of it, so I guess that's still there because you're thinking about it, it's still up there [in your head] and it's still running around in your brain ... God that takes you back. So it never goes, it's always there it's just you may not be reminded so often or you may. (P30)

Being overwhelmed was reported as the second stage of the basic social psychological problem of *hiding behind a mask*. In the second stage of the problem participants felt overwhelmed with *fears of facilitating the death* of the donor. They also felt overwhelmed at witnessing *the graphic nature of the procurement process* and the *negative outcomes of the procedure*. Lastly, as a result of their participation they felt overwhelmed by their *emotional experiences*. As participants moved into the third and last stage *hiding the burden* they continued *hiding behind a mask*.

3.5 Stage 3: Hiding the burden

The third and last stage of *the basic social psychological problem of hiding behind a mask* was conceptualised as *hiding the burden*. As participants assisted in procurement surgical procedures they were forced to contain their own personal beliefs and attitudes towards these procedures. They felt that they were *hiding the burden* of their own personal views whilst undertaking their professional roles. They did this by *hiding behind a mask*. Four aspects of *hiding the burden* were identified: 1) *suppressing personal beliefs*; 2) *hiding an objection to participate* 3) *death and spiritual 'afterlife' beliefs* and 4) *not being able to cope* (See Figure 3.4).

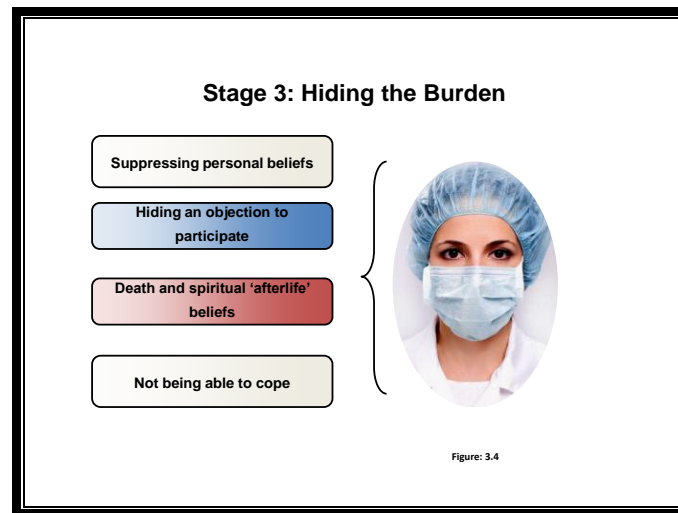


Figure 3.4: The aspects of hiding the burden

3.5.1 *Suppressing personal beliefs*

Suppressing personal beliefs was identified as the first aspect of *hiding the burden*. Participants held a range of attitudes towards organ donation, procurement procedures, transplantation, their right to conscientiously object to participate and views about donating their own and family member's organs. *Suppressing personal beliefs* became a concern for many participants when asked to participate in such procedures. They spoke of *hiding behind a mask* and also *hiding the burden of suppressing their personal beliefs* about organ donation and procurement for fear of being judged. Participants were unable to openly discuss and disclose their attitudes with their colleagues and this was a burden for them as one participant expressed:

No, I tend not to tell people my views because people are usually horrified by what I think because most of the theatre nurses I have worked with in the past are all for organ donation and would give their organs willingly so I tend to be this lone little voice on my own and you're the first person I have ever told ... I am a hypocrite [nervous laugh] and I'm not very proud of it but that is the truth of the matter and I don't really know why it's just this strange I don't know where I'm going [referring to the afterlife]. (P10)

Other participants disclosed that they often suppressed their own beliefs to allow them to survive in their work environment. Due to the emotiveness of the topic in the workplace, the majority of perioperative nurses did not disclose their views to colleagues so they could avoid any debate on the matter: "I sit very quietly and I would say [nothing] ... I don't say anything, I think [by] saying nothing I can't upset anybody. I don't want to force my views on anybody else because it's their choice [whether they want to donate]" (P10). Another participant reported feeling pressured to be an organ donor after discussing her views of being undecided with a girlfriend and nursing colleague:

I know it's a good thing, if others tick it [on their driver's license] I'll tick it too ... my girlfriend, she ticks lots of things and I went, "Oh I'll think about it" and then she said *[Name of Nurse] "What are you afraid of ... why don't you donate your organs when you die ... what are you afraid of?" and she kept kind of pushing me ... I'm scared but I think that it's my [own] judgment or my [own] emotional thoughts [in making a decision]. (P32)

Some participants also reported suppressing the negative attitudes and views they held towards organ donation, multi-organ procurement surgery and transplantation: "I'm nicking organs and that's all there is too it ... that's the way I feel about it" (P29). Participants who were against being an organ donor themselves also reported discouraging their own family members from donating their organs: "Where I can influence my daughter or my husband I kind of do ... that sounds so bad" (P10). This participant gave an explanation of how she would override her daughter's decision if she wanted to be an organ donor: "The very thought of somebody taking organs from my daughter would just be absolutely abhorrent to me even if she carried a card. I would still have to say I don't agree with it" (P10). Although some participants felt they had the ability to influence and discourage their own family member's decision about donation and while their actions

went against their professional role they viewed this as acting in their family's best interest. The same participant further emphasised this point explaining:

I actually don't believe in organ donation, personally I'm a bit of a hypocrite. I would like to receive organs but I don't want to give any and that's an awful thing to say but that's me I'm afraid. I'm a bit like that with my family as well ... to say I would discourage them wouldn't be far from the truth. (P10)

Another participant reported a similar account:

If I was ever in the position of one of my family being in ICU and they [the doctors] came to me and said "Oh we're going to take the organs." They have ticked it [on their driver's license]. I'd probably being placed in that situation in the ICU, I'd probably say "No you're not touching them." I know it sounds bizarre even though I've ticked it myself ... I don't know ... it's bizarre. (P29)

Similar findings were also identified within the literature. A participant in the Korean study by Kim, Elliot & Hyde (2004a) stated: "If my mum and dad were announced as brain dead ... thus someone comes to me and asks about organ donation ... I will never say yes ... *sic* I don't care much about my body ... but for my family members ... well, it's a different story" (p. 304). Moreover, a participant in the study by Shaw (2010) referred to the term of "gift" in organ donation as an inappropriate word by adding "I don't see this as gift at all [...] I see it as a sacrifice" (p. 614). Therefore many viewed organ donation as an altruistic act however there was also a sacrifice made by families in such situations. Similarly, this aspect was also identified within the Australian study by Hyde and White (2010) who explored organ donation decisions amongst their sample of participants who were students and community members. These authors identified that their participants expressed concern for family members grieving over the loss of their loved ones and subsequently the procedure mutilating their bodies as a result of agreeing to be an organ donation. Moreover, other researchers also identified that people were often concerned and opposed to recording their intentions or family's wishes to be organ donors as they often feared they would not have adequate treatment and their lives would not be saved (Childress, 2001). According to Thompson, Robinson and Kenny (2004) a small number of respondents (n=12) in their study also held fears that by signing a donation card this "would affect the medical care received" (p. 52).

In the current study, some participants explained suppressing their own confused thoughts as they were unsure about their views or attitudes towards their own decisions towards donating organs as a result of their participation experiences: "Afterwards [after participation in a procurement procedure] I wasn't sure about organ donation because I found it a bit upsetting" (P18). This was also expressed by another participant:

Look, I would advocate it [organ donation], but I'm not sure that I would advocate my own [laugh] that sounds selfish doesn't it ... I don't know though [to donating ones organs] ... I still think back on that night seeing the

way in which it was done [the procurement surgical procedure] it was almost, seemed like a desecration of the body, but the body is dead, so I don't know [long pause]. I'm still undecided ... I am a work in progress still thinking about it [being a donor]. (P17)

Participants in evaluating their beliefs and attitudes were also undecided as they witnessed firsthand what happens to the donors' body. Some participants even expressed concern picturing themselves lying on the operating table following the procedure:

I think it's both yes and no, I'm an organ donor, but having said that when we had cleaned him [the donor] up ... I just thought my goodness it's a really funny thought that occurred to me and I'm thinking I'm going to be lying there all empty inside [nervous laugh]. It's the weirdest thought and what a thought to occur to me, that it's just going to be all hollow in there [the body cavity]. (P22)

Some participants, in suppressing their personal beliefs reported that they would leave the decision of donating their own organs for their family to make on their behalf at the time of their death:

I think as far as what I did [participation in procurement], the conclusion that I did come to was I told my family it's their decision what they do once I'm gone [deceased]. It's their decision whether they donate my organs or not. I don't know if that makes it easier for them or not. (P18)

Other participant's held the belief that although they would donate their organs they would specifically not donate their eyes as an organ donor. Several participants suppressed this belief from their peers and colleagues on discussions about organ donation however emphasised these intentions to their relatives and disclosed this to the researcher: "Yes, I would donate everything, except my eyes ... I've already told my husband not to change this once I have died ... [laugh] I'd just like to keep my eyes" (P16). Another participant stated that she may require her eyes at the time of her death:

Its more the fact that I came here with most of my organs ... I don't know where I'm going to [at the time of death], so I want to go with everything I've got particularly my eyes ... and that sounds like a really strange thing to say but because I want to keep everything just in case I need it when I get there [referring to the afterlife]. (P10)

Similar views were also presented within the literature. In the earlier study by Kent and Owens (1995) participants also provided similar reasons to not donate eyes due to: "the belief of seeing into the next life" (p. 490). In the current study, participants also suggested that they would not donate eyes as they held the belief that eyes were the soul of the body. This was referred to by several participants as: "Because to me [eyes] ... are like the windows of your soul" (P23) and "I think that the eyes are the soul of the human body" (P21). This was also validated by the recent study by Haddow (2005) where it was also emphasised a person's eyes were referred to as the "windows of the soul" (p. 103).

Moreover, within the literature, conflicting attitudes to corneal and organ donation were also identified within the literature. The earlier study by Kent and Owens (1995) also revealed that nurses disliked donation of the eyes and held fears of disfigurement: “All other organs are internal you can see the eyes” (p. 490). Similarly, this was also identified in the study by Shaw (2010) which explored the perceptions and views of gift discourse on organ donation from critical care specialists (intensivists) and both, donor and recipient coordinators. Findings from this study also revealed that many of these health professionals encountered refusals towards donation of the eye as it was viewed as a visible desecration. A participant from this study stated:

Most of the feedback I get, because we do very badly with corneal grafts or donation of the eye is actually due to desecration, intentionally visible desecration. So you know, “you can do a cut from here to here and take what you want from the inside, just don’t touch the face”. (Shaw, 2010, p. 614)

Participant’s, in the current study also expressed cultural beliefs as also playing an important role in their attitudes and beliefs about organ donation and procurement and these were responsible for some participants *suppressing personal beliefs*. One participant explained her views and attitudes on organ donation which stemmed from ingrained cultural beliefs about having a whole body at the time of death:

I suppose in some respects I do hide my beliefs, it is part of the culture but that was just how I felt. It was never actually spoken about at home but this was always the perception ... you come into this world as one being and you go, you leave this world as a whole [referring to the whole body intact].(P20)

Similarly, research into cultural beliefs about organ donation support that many cultures deemed it necessary to have a whole body at the time of a person’s death and therefore do not support organ donation. Kim, Elliot and Hyde (2004b) in their study on Korean health professional’s attitudes and understanding towards organ donation and transplantation reported external cultural factors as influencing their attitudes to organ donation. These authors found that various superstitions and cultural beliefs inhibited organ donation and people believed that the body must stay whole so as not to cause suffering in the afterlife. Moreover, a transplant coordinator in their study also reported the belief that donors as a result of the procurement procedure were dying twice by the following comment: One cannot stab or knife into the dead body, because that implies killing the body twice” (Kim, Elliot & Hyde, 2004b, p. 150). Similarly, the study by Pelletier-Hibbert (1992) examining the family’s perceptions of stressful situations during the donation period highlighted similar doubts of whether donors are resting in peace as a result of donating organs. A participant, a mother in this study held doubts and was unable to gain closure after agreeing to donate her son’s organs: “I can’t accept that he is completely dead I’ll always wonder whether he is really resting in peace because there are parts [organs/tissues] of him still alive somewhere in this world. So to me it’s like he’s not completely dead” (p. 94).

3.5.2 *Hiding an objection to participate*

Hiding an objection to participate was the second aspect of participants experiencing *hiding the burden*. As conveyed by several participants their participation in procurement surgical procedures occurred suddenly with little opportunity to object to participating as a result of several organisational factors and staffing issues. Therefore *hiding an objection to participate* occurred when participants had pressures to fulfil their work roles knowing that they could not be replaced if they did not do what was asked of them: “If you are on a late shift and there is only two or three of you [on duty] and one of you or even two of you [conscientiously] object you know, What is the protocol then?” (P10). Other participants spoke of scenarios where they were on-call and were faced with having to participate in a procurement procedure even though they may not have wanted to participate in such a procedure there was no one else available to cover their on-call roles: “It is two thirty in the morning who else can we get in? There was no other [nurse] on the on call team” (P24). This was a common occurrence as another participant in a similar situation was also caught out whilst undertaking an on-call shift: “I was doing somebody else’s call and I got called in to do the organ retrieval for them. I didn’t have an option but to participate” (P21).

Several participants spoke of the hidden burden they carried in having to participate in these procedures with no alternative offered to be replaced as a result of the workplace dynamics and staff mix: “I wouldn’t say [I was] given the option it’s just part of the job ... there was no other option ... there was nobody else to do it ” (P7). This view was also validated by another participant who emphasised: “It’s part of the job in theatre ... to do whatever comes through the door” (P12). Participants also emphasised that the skill mix of staff was another factor which hampered participant’s rights to object to participating: “Sometimes there is no one ... sometimes it’s the skill mix ... it’s whether there is that staff or the backup is available to swap around” (P35). A similar view was provided by another participant:

There wouldn’t have been anybody else to do it ... we had limited staff on to do your afterhours theatres ... I was basically allocated ... the skill mix of staff ... I was the most appropriate person to scout for this procedure ... so no I wouldn’t even have had the opportunity to refuse [to participate]. (P13)

Participants further spoke of *hiding an objection to participate* in procurement procedures as they were uncertain of their rights to express a conscientious objection within the perioperative nursing specialty. This was observed and noted as a grey area as several participants voiced uncertainty in raising a conscientious objection towards procurement surgical procedures. As stated by McHale (2009) “The nurse may be fundamentally opposed to a particular procedure or treatment approach because of her personal religious or cultural beliefs, but should that entitle her to refuse to be involved in that procedure or treatment?” (p. 1262) A conscientious objection as defined by the Australian Nursing Federation (2011) in their policy statement on conscientious objection is noted as:

Nurses, midwives and assistants in nursing (however titled) have a right to refuse to participate in procedures which they judge, on strongly held

religious, moral and ethical beliefs, to be unacceptable (conscientious objection). Fear, personal convenience or preference, are not sufficient basis for conscientious objection. (Reviewed and re-endorsed, June 2011)

In the current study, a lack of awareness and knowledge of a conscientious objection was noted as predisposing several participants to hide a personal objection. People were obviously confused about their rights to conscientiously object and their own personal desires to not be involved in a procurement procedure. This confusion was evident in the examples participants provided of when they believed they could voice a conscientious objection even though they fell outside the criteria or definition of a conscientious objection: “As far as I’m aware we are able to say that we are not comfortable and I think we are able to say that yes we are not prepared to participate in those [multi-organ procurement surgical] cases” (P11). However due to the obvious lack of uncertainty of their rights and whether they could conscientiously object, several of these nurses felt that they had no choice but to assist in these procedures. This lack of understanding was further exemplified by several participants when they substantiated when they believed they should be able to express a conscientious objection, for example due to emotional reasons or a lack of knowledge or limited experience within these procedures: “I guess my first [multi-organ procurement case] for me personally is I don’t want to do this because I didn’t know what to expect” (P13).

Other nurses had some knowledge about when they could voice an objection such as when having a religious objections or a moral objection: “People might have religious objections to it [participation] in these procedures” (P10); “If we are against organ donation ... we should be allowed to refuse to be a part of that [participation] certainly ... I do think that as a nurse if you are morally opposed then you shouldn’t be involved in it” (P18). Although these examples fit into the definition provided by the Australian Nursing Federation, several participants spoke of their organisations ignoring to honour a nurse’s conscientious objection in the workplace due to a lack of adequate staffing levels. Several participants therefore felt that they could not voice a conscientious objection when it was ignored by their line managers and the organisation where they were employed: “I know of some nurses who do have religious objections they have asked not to participate but they still had to” (P21). These nurses although reported the importance of voicing their objections felt burdened when their views were dismissed:

If you had a conscientious objection you should be able to ... sort of voice that and not be ... dismissed as it’s irrelevant you have to go and do it anyway ... I wasn’t given the opportunity to refuse ... and I had to still participate. (P13)

Participants explained that *hiding an objection to participate* occurred when they were never really asked whether they were happy to participate in procurement procedures: “I don’t know that I was asked specifically [to participate]” (P12). Whilst another participant reflected: “I wasn’t given the opportunity [to decide whether I’d like to participate]” (P13). Being placed in a position of not having a choice to participate was of concern to several participants: “Like some people mightn’t want to, would rather not participate in it ...”

(P28). Being asked if they wanted to participate was viewed as important as it gave the perioperative nurse a way out of assisting if they were unhappy to do so: “The way that I feel about being involved now is ... [long pause] I like to be asked and I like the nursing staff who I am involved with to be asked by the co-ordinator [if they want to participate or not]” (P15). Another participant concurred:

So I think with the junior nurses it’s almost like they need, they need to be individually asked whereas with more senior nurses its well if they are going to do it [participate] they will put their hand up themselves. (P6)

Although several nurses disclosed that they wanted to be asked whether they would like to participate in procurement procedures they noted that they were afraid to express such an objection as they feared they could be discriminated, or they faced being ostracised for creating added pressures and strain on the surgical team. Therefore, several participants spoke of *hiding an objection to participate* as a result of not having the confidence to speak out as they feared that they would be judged by their colleagues: “Some [perioperative nurses] wouldn’t speak up for themselves but I know some [nurses] would ... the first one I [myself] probably didn’t have the confidence [to conscientiously object]” (P21). Other participants avoided objecting to participating as they felt they would not be supported by their peers: “As to whether you would be supported knowing the staffing shortages and knowing what is normally said I couldn’t guarantee that you would actually be allowed to be exempt from it [participation], that I couldn’t guarantee” (P11). A few participants reported that people were discriminated and ostracised from the team when they refused to participate:

We have had a staff member who refused ... and they [were] a little bit discriminated against and they were almost isolated from the group, from the team. She just didn’t, blatantly didn’t agree with what we were doing. I think it was very confronting for her and probably her morals or beliefs and things like that. (P25)

A broader issue around participants having a conscientious objection to participating was the increased pressure and strain on the rest of the department and surgical team to undertake such procedures: “When some people refuse it puts a lot of pressure on other people to pick up that role as that might not have been their theatre to work in or their speciality” (P12). The same participant elaborated on their personal frustrations and feelings when others refused to participate in procurement procedures. They believed that all perioperative nurses should be sharing this burden and load:

There are days when we have to do things that we don’t like, there are sad cases and horrible cases and I think if we start [to] ... pick and choose what procedures we are involved in, this could lead to affecting other staff on the floor in particular junior staff or staff who aren’t capable of saying well actually I really don’t want to do this case either. I think it should be shared out evenly I don’t think it should rest on one or two people who are just happy to do the cases ... I think ... there’s no other specialty where you can say I don’t do this procedure, I don’t do hips because I don’t like them that

does affect me a little bit. I think it's a little bit unfair on the team the rest of the team on the operating floor ... it can unfairly disadvantage other staff on the floor [the operating room floor staff]. (P12)

The non-participation of some nurses in these procedures produced a negative undercurrent in the theatre and added to the overall level of stress in the workplace: "We just walked straight into this [procurement procedure]. I think the culture needs to be made within a unit that, that it's okay to say no I don't want to be involved in it" (P18). Within the literature there was no evidence of the right for nurses to express a conscientious objection towards participating in procurement procedures. However, as noted in the study by Van Da Walker (1994) investigating the attitudes of operating room nurses towards organ donation one participant emphasised the importance of participating in procurement surgery as necessary to sustaining her job: "I would lose my job if I didn't take part" (p. 77).

3.5.3 Death and spiritual 'afterlife' beliefs

Death and spiritual 'afterlife' beliefs was identified as the third aspect of *hiding the burden*. It was noted by several participants that they were often confronted by their own thoughts of *death and spiritual 'afterlife' beliefs* after participating in a procurement procedure. They referred to spiritual care as providing comfort at the time of the donor's death. Participants also spoke of treating the donor as a person with dignity and respect which extended beyond the period after the procurement procedure which participants reflected as the time that the soul leaves the body. As the last health professional group to care for these donors prior to them being transferred to the morgue, several participants reported wanting to ensure that they provided and honoured each donor patient with appropriate spiritual and end of life care. However, it was acknowledged that some participants lacked knowledge about how to provide care to a deceased donor patient within an operating room context. As reported a few participants felt out of their depths during this time: "I can't do this [assist with post mortem care]" (P9); "I don't know what to do at the end [when caring for the donor]" (P32). Similar findings were reported by Milligan (2004) who verified that inadequate training and education of nurses in spiritual care hampered the provision of providing care to patients at the time of their passing (p. 168).

In the current study, efforts to provide spiritual 'afterlife' care were sometimes hampered as there was no uniform approach to ensuring patients received adequate spiritual end of life or post mortem care within the operating room environment due to time constraints, lack of a suitable environment and the inability of staff to confidently undertake such care. Participants felt that donors should be afforded the time for this care to take place and were *hiding the burden* when this did not occur to an appropriate level: "I felt some guilt that ... we'd let this person die without any, I don't know whether spiritual is the right word but acknowledgment that they are gone" (P26). Another participant reported being placed in a situation of having to provide post-mortem care quickly to a deceased donor on the operating table whilst another live patient was in the anaesthetic room waiting to come into the theatre to have his scheduled hip surgery: "There was no time, as we had the other

patient waiting in the anaesthetic room ... I felt awful as I had to rush the care I provided to the donor" (P16). Therefore, these situations placed perioperative nurses in a difficult position, experiencing feelings of guilt that they were not always able to honour these donors by providing appropriate and timely spiritual care. Milligan (2004) also concurred with this finding when reporting that 88% of post registration nurses studied also stated that their "efforts to provide an appropriate level of spiritual care were hampered by insufficient time" (p. 168).

In the current study, participants further explained feeling burdened by not being able to provide the best possible care to donors from diverse cultural and religious backgrounds. Participants reflected that they often lacked knowledge and felt unprepared for the various cultural aspects of care required for deceased patients, as they were not routinely caring for deceased patients within the operating room environment. One participant provided an example, of this occurring when confronted with a Jewish patient who had died and was unsure at the time of how to provide their post mortem care after a procurement procedure. However, the same participant acknowledged that when caring for a subsequent Jewish patient she was better able to provide this care in line with their cultural views: "If it was a Jewish person we wouldn't touch them ... I've done a Jewish gentleman and we weren't allowed to touch him until the Rabi came so obviously [we have to] respect their cultural and religious beliefs" (P10). This aspect was also reported in the literature by Mongoven (2003) who emphasised that certain cultures and religions, such as the Jewish faith practiced burying their dead on the day of the death before sundown.

In this current study, participants reported that they did not openly discuss their views on *death and spiritual 'afterlife' beliefs* with their colleagues. Some participants reported experiencing discomfort and uncertainty at how to provide care to the donor amidst their colleagues:

Everyone just walked away and just went into a cocoon, not knowing what to do, so not doing anything and sort of almost like [there was] an embarrassment [amongst the team] not knowing how to handle this dead person [donor] ... I don't know ... it was as if ... they don't know what they're meant to do. They don't know if they meant to acknowledge that somebody has just died or just pretend that they're not there [or] pretend that the body is not there. (P26)

Moreover, the same participant elaborated further:

There's some sort of barrier about talking about it or to each other or whether people would want to have a moment's silence where you acknowledge that this person has died. But I mean that's the embarrassment, people are too embarrassed to even suggest that to each other. (P26)

Participants disclosed their own beliefs about death and the 'afterlife' holding various personal views about the donor's spirit and soul at the time of their death: "Once the heart is stopped that is when your soul is actually taken ... the body has to go back to spirit where

it came from" (P21). However another participant after dealing with both the brain dead and the DCD donors questioned the unnatural way these donors had died and struggled with thoughts of where the donor's spirit had gone:

Well, I'm a Christian and I call myself a believer so I believe in heaven and I believe in hell and I have struggled with well, this person [the donor] has died whatever the circumstance or situation but where's their spirit, where's their soul. Are they in heaven or are they in hell? (P25)

At the conclusion of the procurement procedure several participants spoke about their belief that the donor, who was now dead, was still aware of their surroundings and the discussions taking place around them: "I like to think they're [the donor is] watching, I like to think that they are watching [referring to the care being provided] ... I like to think they are" (P33). Moreover within the literature, respondents in the study by Wolf (1991) also emphasised this perspective when providing post mortem care for organ donors: "When patients die, some nurses believe that the spirit of the person hovers about the body" (p. 75).

Moreover within this current study, nurses felt it was disrespectful to provide post mortem care whilst discussing personal conversations. They believed in treating the donor with dignity and respect during this time as they feared that their actions were being watched or heard by the donor:

I didn't want to talk about anything else ... I felt it would be very disrespectful to talk about other things ... I do go into things like... I wonder if he [the deceased donor] is watching us ... I wonder if he can see us ... I don't want to be brash with the body I want to be very respectful of this body you know. (P22)

Several participants were mindful that hearing is the last sense lost when patients are being anaesthetised. Therefore, many participants held the belief that although the donor was deceased they could still hear what was occurring in their surroundings. Therefore, some participant held fears that the donor's spirit was listening and observing the level of care being provided by the nurses. This made them feel uncomfortable as they felt that they needed to provide a very high standard of care as the donors spirit was observing what they were doing. Other participants recounted talking to the deceased donor and explaining the care they were providing: "I think I was just still talking to him, when we moved the patient, taking lines out and saying "Sorry" calling his name, because I don't know it was really weird not to do it ... but I just did" (P32). Another participant tried to normalise her care recounting that she tried to care for the deceased donor patient as if they were still anaesthetised, like any other unconscious patient within the operating room:

When we were doing the last offices, I always speak to the patients because I have heard that their hearing is the last thing that leaves [referring to when patients are anaesthetised], like the patient can still hear you, so I always speak to the patient as if they're still alive and I always explain to them what I am going to do next. (P21)

3.5.4 *Not being able to cope*

Not being able to cope was identified as the fourth component of *hiding the burden*. *Not being able to cope* with their participation in multi-organ procurement procedures forced many participants to be *hiding the burden* and this further exacerbated the basic social psychological problem of *hiding behind a mask*. The majority of the participants recounted to the researcher that they were not able to cope with procurement surgery on many levels which left them feeling isolated and vulnerable. However, they hid these emotions from their colleagues as displaying such emotions was a sign of weakness which reflected on their ability to perform in more demanding emergency trauma roles in the future:

In my personal experience I think everybody gets upset but if you constantly get upset I think it perhaps shows ... the thought is that it shows a sign of weakness but you are not going to be able to cope with more horrific things that come in [through the operating room] and I was very young and often it was put down to oh it's because she's young and so I think I've always believed there should be more support. Particularly for younger people and in my experience in theatre I've seen a lot, a lot of horrific things and I've had no other person that I could ever go to and I would hate to think anybody else had gone through some of the things that I've had to experience. (P10)

Several participants reported that there was an associated stigma directed towards them from colleagues if they sought support because of *not being able to cope*. One participant experienced being judged by her colleagues when she questioned when support such as debriefing and counselling would take place:

I said, "Well where's the counsellor?" And they all looked at me as though I was stupid. [They said] "What are you talking about?" and I said "Well we should have a counsellor here to talk this out." [They replied] "You be my counsellor and I'll be your counsellor [Name] and that's about it". (P29)

Participants also described the experience of being questioned and judged when they took time off during work hours to seek external support such as counselling:

Where are you going? [her colleagues asked] ... get over it [when she told them she sought counselling] basically which is the mentality of some of the older staff it's like well get in, get on [with the procedure] and get out [get it done]. (P19)

Several of the participants expressed the need to suppress their feelings of *not being able to cope* as it was important that they focused on their role and responsibilities in the workplace. They hid the burden they were carrying and did not speak of it to anyone. One participant recounted her experience of working with an older and experienced perioperative nurse who did not allow for any discussion of feelings whilst undertaking a multi-organ procurement surgical procedure: "The old 'sister' when she did it, she had done loads of them and again you just got on with it and you didn't talk about your feelings"

(P10). Similarly, another participant experienced being ignored when she wanted to express her concerns after participating in a procurement:

I'm one of those people that likes to talk about things ... it was like okay just shut up and get on with what you're doing ... but I found that I haven't been able to [talk to anyone], no one talks about anything down there [referring to theatre staff]. (P19)

Many of the perioperative nurses who were interviewed for this study felt burdened by keeping their feelings to themselves and this behaviour became ingrained as part of the perioperative nursing culture. When the researcher asked these nurses why they would not divulge any personal issues they responded that it was easier to say that they were okay to their team members:

I think, it's getting into sort of the fact that we are all involved in a caring profession, nurses don't tend to care for themselves very well ... and none of us are really trained to counsel or perhaps you know that's an extra job that we take on ... counselling skills or even debriefing. I think a lot of us just are not experienced in that area other than just saying, "do you feel okay?" or "how are you?" ... as I say it's usually something that you just say afterwards ... I find most people they usually ... just kind of keep their feeling to themselves. I think most people say "yeah I'm okay, yeah I'm fine" ... no, there is never any debriefing. I think only if there has been a really big critical incident would you ever find that there is any debriefing. (P15)

Participants did not disclose that they were *not able to cope* due to trust issues, a lack of confidentiality and gossiping that frequently occurred about staff performance in the operating room. Therefore by *hiding the burden of not being able to cope* they protected themselves from being judged by their colleagues and feeling embarrassed. One participant described the following situation:

I'll tell you why that happens here [theatre]. I think it happens here because there's a huge trust issue that if somebody goes and speaks to somebody about something that it doesn't stay there. You know I think people need to know if it's kind of an open door policy ... come and tell me something's wrong then there should be ... a bit of confidentiality about that and it stops there. People need to know that if I think it was personal, you know they're my personal feelings, you know being up front about emotions if they feel that's not going any further and I think here it does, I think it does. I know it does. (P23)

Moreover, participants described the underlying stigma attached to *not being able to cope* as being exacerbated when perioperative nurses were not supportive of each other: "I would say peri op's [nurses] are the worst I think at supporting each other ... you know there is an element of a stiff upper lip I think in theatre you know" (P23). This aspect was noted by many of the study participants who reported similar experiences of not feeling supported by their peers. One participant highlighted the judgements made and lack of support provided by fellow colleagues:

I think that certainly, that's in nursing isn't it, I mean we probably are the least supportive of each other in some situations on some levels and stuff, you know there are some nurses that do pass judgments in those situations and I think that they shouldn't. (P19)

According to Wlodarczyk and Lazarewicz (2011) who investigated the frequency and burden of Polish nurses' experiencing ethical conflicts found that the nurses in their study did not report the burden of ethical conflicts in their work and as a result experienced higher levels of burnout. Further these authors stated: "Confessing to own weaknesses is not taken well in the professional environment" (p. 859).

3.6 Summary

This chapter presented the basic social psychological problem of *hiding behind a mask* which was experienced by perioperative nurses participating in multi organ procurement procedures. *Hiding behind a mask* was a shared concern for the study participants and the problem was comprised of three stages: *being unprepared*; *being overwhelmed* and *hiding the burden*. Participants articulated hiding throughout all three stages of the basic social psychological problem. In the first stage, participants reported *being unprepared* when *being confronted to participate* in the procurement surgical procedure as they lacked knowledge and experience often *not knowing what to expect* of the procedure or their professional role. As a consequence, several participants were unprepared for being *exposed to death* and the occurrence of death in the operating room and found it difficult assisting with *operating on a cadaver donor and dealing with the grieving family*.

As participants moved into the second stage they reported *being overwhelmed* with *fears of facilitating the death* of the donor and of having doubts about whether the donor was really deceased as a result of lacking understanding of brain death testing. Participants also felt overwhelmed at the graphic nature of what was being witnessed and their *emotional experiences* and responses to their participation in these procurement surgical procedures. In particular participants were overwhelmed by their experiences of undertaking care of DCD donors within the perioperative environment, having to witness their death and then proceed with their procurement surgical procedures.

Lastly, the participants moved through the third and final stage, described as *hiding the burden* and in this stage they reported suppressing their personal beliefs and attitudes and their right to have a *conscientious objection* to participate in these surgical procedure. As a result of dealing with deceased donors several of the participants were confronted with their own thoughts of *death and spiritual 'afterlife' beliefs* which challenged their views of ensuring they were providing appropriate levels of spiritual care within the operating room environment. Lastly, the participants were burdened by *not being able to cope*. The study participants moved through the three stages dealing with each aspect as a result of their participation in multi-organ procurement surgical procedures. All of these three stages contributed to the identified basic social psychological problem of *hiding behind a mask*.

CHAPTER 4

Conditions Influencing the Basic Social Psychological Problem of Hiding Behind a Mask

“The problem will emerge as well as the manner by which the subjects involved continually process it” (Glaser, 1992, p. 21)

4.1 Introduction

This chapter presents the conditions that influenced the perioperative nurses’ experience of participating in multi-organ procurement surgical procedures. Data analysis revealed that the basic social psychological problem experienced by perioperative nurses that emerged from the data was called *hiding behind a mask*. In order to understand and explain why and how the problem occurred, the researcher sought to identify the relationships of each of the categories related to the core problem such as the conditions and consequences. As stated by Glaser (1992) “the grounded theorist simply codes for categories and properties and lets whatever theoretical codes or coding families emerge where they may” (p. 63). This chapter presents in detail the conditions influencing the basic social psychological problem of *hiding behind a mask* with rich quotes provided to exemplify the participant’s experiences.

4.2 Conditions influencing the problem of hiding behind a mask

Participants experienced the problem of *hiding behind a mask* as a direct result of participating in multi-organ procurement surgical procedures. In this study, the researcher identified that the emergent theoretical code or conceptual model was a causal-consequence model (Glaser, 1978, p. 74) which linked the categories of the substantive theory together. The conditions which emerged from the data were identified as “causal” conditions and the basic social psychological problem of *hiding behind a mask* was identified as the “consequence”. These causal conditions were identified as the negative factors which influenced the problem and further compounded perioperative nurses’ experiencing *hiding behind a mask* when participating in multi-organ procurement procedures (See Figure 4.1). Three conditions were identified in the data which influenced the participants’ experience of the problem. These were: 1) *work conditions*; 2) *levels of knowledge and experience* and 3) *levels of support*.

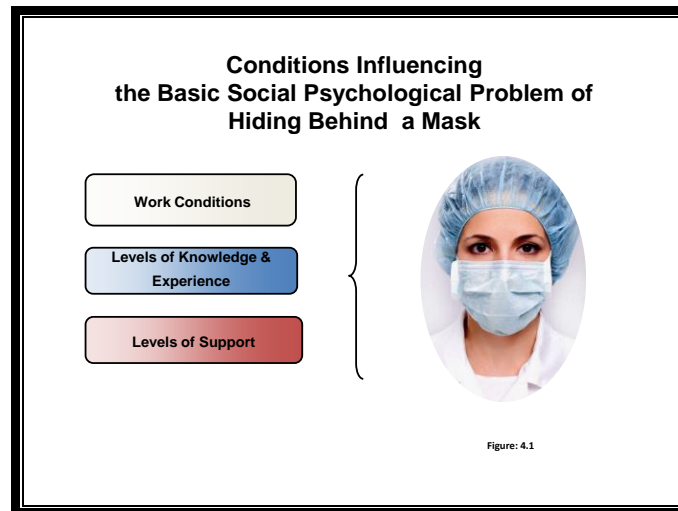


Figure 4.1: Conditions influencing the basic social psychological problem of hiding behind a mask

4.3 Work conditions

Work conditions were identified as the first condition influencing the basic social psychological problem of *hiding behind a mask*. Participants within this study articulated that as the operating room environment was geographically cut off from other areas they often felt isolated as they could not seek support. Participants also spoke of the challenges of working in an environment whilst having to deal with an oppressive work culture which predisposed them to containing their own professional and personal trauma associated with their participation in procurement surgical procedures by *hiding behind mask*. Four components of work conditions were identified: 1) *working behind closed doors*; 2) *the operating room work culture*; 3) *non disclosure about the procedure* and 4) *waiting for procurement surgery* (See Figure 4.2). The majority of the participants in this study articulated that the various negative influencing conditions identified, compounded and directly contributed towards their experiences of *hiding behind a mask*.

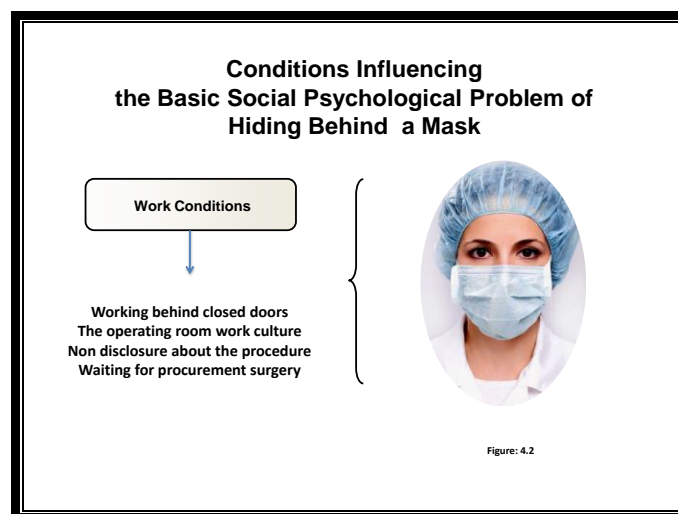


Figure 4.2: The components of work conditions

4.3.1 *Working behind closed doors*

Working behind closed doors was identified as the first component of *work conditions*. Participants articulated that as the operating room environment is geographically isolated from other areas of the hospital their professional roles were primarily referred to as being undertaken in isolation or hidden behind closed doors. *Working behind closed doors* was seen as contributing and exacerbating the basic social psychological problem of *hiding behind a mask* as participants felt that there was little recognition for their role or their professional existence and the associated problems they encountered in their day to day professional roles whilst *working behind closed doors* of the operating room.

Several participants in speaking of their operating room work environments placed their experiences into the context of *working behind closed doors*. Similarly, the operating room environment has often been referred to as a mysterious work environment with little knowledge of what occurs *behind the closed doors* by not only other nursing specialties but the general public: “Like we are a forgotten industry [the specialty of perioperative nursing] to be honest we are, we’re behind the mask and a lot of people don’t understand our role” (P4). As noted by one participant their professional roles were often obscured by medical professionals working within the operating room such as surgeons:

The general public, have a funny idea about what happens in an operating theatre. ...it’s always the surgeon who is the boss. So we still have patients coming in and saying “Oh, I didn’t realise there was going to be [any] nursing staff involved in my operation!”... They think the surgeon does it [the surgery] all by himself ... The general public know that there is someone looking after the patient because the patient is asleep and they know [it] is the surgeon doing the operation but how that surgeon does the surgery it really doesn’t come up high on the visual or the consciousness of the general public at all [nervous laugh]. (P8)

According to Furlow and Hoglan (1994) who wrote about the operating room environment behind closed doors also stated that: “Operating room (OR) nurses are a unique breed. To understand them, one must understand the environment in which they practice (p. 25). In this study, this was similarly emphasised by the study participants who articulated how others perceived the role of the perioperative nurse:

The perception of theatre nurses is we are behind closed doors. I don’t think many of the public have any understanding of what we do. No one in, [or] outside of [the theatre] knows what we do, I think a lot of general nurses have no idea of what we do let alone the general public have any idea. (P29)

Working behind closed doors, perioperative nurses often witnessed the most traumatic patient injuries, death and trauma and these experiences could not be comprehended by others unless they had experienced similar events themselves. Participants explained that this often left them socially isolated from other nursing colleagues working in other areas of the health care system, who lacked an understanding of what perioperative nurses experienced when participating in surgical procedures such as procurement surgery.

Moreover, other participants spoke of the daily isolation of working behind the closed doors of individual operating rooms and being only visible to the surgical team working inside. This reinforced their feelings of isolation and *working behind closed doors* as the only people they had contact with for this extended time were the members of the surgical team.

Within the literature there is also support that perioperative nursing work and contributions to patient care is often unrecognised or is invisible to the public and other health professionals (Bull & Fitzgerald, 2004b; Leathwick, 2005). McGarvey, Chambers and Boore (2000) referred to the operating room environment and the roles of perioperative nurses as 'largely hidden from view' (p. 1092). These authors concurred that surgeons, medical staff as well as perioperative nurses viewed the theatre as a 'private' area away from conscious patients tucked away out of sight. Moreover, an Australian ethnographic study undertaken by Bull and Fitzgerald (2004b) also noted that the perioperative nurses' role is viewed as 'invisible' with limited appreciation of their contribution by both patients and other nursing colleagues. According to Bull and Fitzgerald (2006): "A negative consequence has been the criticism, both from outside and within the nursing profession, that OR nursing is a 'technical' rather than 'nursing' undertaking" (p. 3). Similarly, perceptions about the role of the operating room nurse was largely viewed as a technician, working with surgical instruments and technically assisting with surgery as opposed to providing nursing care (Bull & Fitzgerald, 2006; Riley & Manias, 2002).

In this study, several participants who were involved in procurement procedures also reported there was little recognition of the perioperative nurses contribution towards these surgical procedures and that there was a nursing input towards donor patients care: "I don't think the patient, or just normal ordinary people [the public] out there, they don't really know ... much about the [procurement surgical] procedure or that we are involved in these procedures" (P30). This point was emphasised by another participant:

So public perception of what happens in an operating theatre is extremely limited and therefore from a perioperative nurse point of view involved in organ procurement I would think that most families and most [people in the] general public personally don't put us on the radar as part of the team they just know that the doctor does it [the procurement surgical procedure]. (P8)

Several participants felt that their exposure to traumatic experiences due to participating in procurement procedures should be hidden behind their mask and also behind the closed doors of the operating room. As noted by one participant this occurred from the time the patients were transferred and accepted through the doors of the operating room:

They [the donor] just come to the front door [of the operating room] and then once they the donor go through, the doors close and that's it we've got the patient [the donor] to ourselves or the body to ourselves that needs the procurement done. (P25)

Several participants viewed their participation negatively and felt shame and guilt which they kept within themselves. The environment of *working behind closed doors* was therefore conducive to suppressing these feelings from other people external to this work environment. For some participants feeling negatively about their participation, whilst suppressing feelings of shame and guilt exacerbated the problem of *hiding behind a mask*: “I always felt terrible about the work I did in procurement procedures” (P29); “It sometimes comes up in my mind too whether what we are doing is right or wrong” (P25); “I can remember one of the younger nurses said “I can’t believe I’ve just done that ... that someone [the donor] has died in our hands” (P29). Other participants in other studies also expressed feelings of guilt at being involved in the organ procurement process. A participant who worked as a transplant coordinator in the study by Kim et al. (2004a) stated:

... Whenever I’m watching the organ harvesting operating, I feel guilt and skepticism, which are from the question, is it really a good thing? Am I really doing well in this job? that’s too cruel.... such a feeling makes me so depressed and frustrated. I sometimes suffer the qualms of conscience. (p. 303)

In this current study participants also disclosed that when organ donor awareness days or events were planned that there was no presence from the perioperative nursing profession or even an acknowledgment that they were part of the team involved in procurement procedures: “We never get invited to these events we are always stuck behind the closed doors of the operating room” (P24). The participants of this study emphasised this as a significant lack of recognition of their roles within procurement procedures, at these events. Often these events were publicised after the event and numerous perioperative nurses spoke of reading of such events: “You read stories of ICU [intensive care nurses] and critical care nurses attending such events but not OR [operating room] nurses” (P24). In many ways these situations reinforced to participants the physically isolating work environment in which they work and the need to hide their experiences behind their mask as it was viewed that their roles were not recognised or they a voice to talk of their plight when assisting in these procedures.

Several participants spoke of feeling constrained to talk about their work experiences as they were physically isolated behind the closed doors of the operating room. In addition, they held fears that other specialty nurses would not understand their experiences. Participants further acknowledged that although their work in procurement was hidden and not acknowledged that it was important for their work in procurement surgical procedures to be acknowledged from behind the closed doors of the operating room. Participants held the firm belief that once acknowledgement was recognised then they could seek support to better manage these procedures and the emotional impact:

I really think that this is great, that you [the researcher] are actually ... highlighting the perioperative nurses’ [participation role] and it goes to improving our role, seeing what we do because its behind closed doors, and that we wear funny clothes and people don’t really realise that

perioperative nurses [that] we are nurses for a start and that we provide you know 100% patient care. (P2)

4.3.2 *The operating room work culture*

The operating room work culture was identified as the second component of *work conditions* which was reported as influencing the participant's behaviour of *hiding behind a mask*. Participants articulated that *the operating room work culture* was often an oppressive work environment where nurses had to contend with factors such as workplace bullying, hostile and offensive behaviours and a lack of support. Due to the geographically isolated work environment of the operating room these negative situations often flourished, with nurses suppressing such events. Therefore there was a cultural expectation for nurses to conceal such experiences and events.

As a result of *the operating room work culture* several participants felt uncomfortable bringing attention to themselves when they encountered work related trauma such as procurement surgery as culturally they were expected to cope within this stressful work environment: "Theatre nurses do have a certain culture of having to cope, I suppose" (P24). There was a huge expectation that once you commenced working in this specialised field regardless of experience, coping was expected and you had to focus on your professional work role: "You've got to just put your nose to the grindstone, keep working it doesn't matter, what's happening around you" (P29) and "It's been like that ever since I started nursing ... you were expected to cope regardless" (P19).

Moreover, several nurses explained that when assisting with procurement surgical procedures the culture of coping was further reinforced by more senior nurses: "Even at *[Hospital Name] I know some of the older staff were very, this is the way it is ... you just will have to cope you know ... well you'll have to cope clinically and emotionally" (P19). Therefore nurses had to contain their emotional and traumatic experiences: "No, your sentiments and feelings you would never have exposed to your colleagues" (P17). Therefore this cultural expectation exacerbated the nurse's behaviours of *hiding behind a mask*: "I think you're expected to just accept it [the traumatic situation of procurement surgery] and get on with it, at times" (P24). When placed in these situations participant's spoke of deliberately keeping quiet and bottling up their emotions:

Whilst there might have been a few soft hearts amongst them [nursing sisters] you never did try to find out which one it was. And you never exposed your feelings along those lines ... I wouldn't have dared to come in and said to the charge nurse "I'm really upset". (P17)

Other participants spoke of the culture within the perioperative area as one of shunning people who appeared not to be coping. This was similarly reported by a participant who experienced another colleague judging her inability to cope when participating in a procurement procedure as well as her ability to be a perioperative nurse: "If you can't cope with this situation [procurement surgical procedures] in your role then you should not be

working here ... in theatre[s] maybe you are not necessarily cut out to work in the theatre environment” (P32).

In this study, a culture of bullying and harassment within the operating room was also noted by some participants as exacerbating their need to be *hiding behind a mask*. Several participants explained that *the operating room work culture* itself allowed such events to take place. They explained that they often felt unsafe to talk about any problems they encountered in the work environment due to a lack of support and distrust in the work environment with several nurses struggling to overcome these situations:

The culture [here] is, like we go through phases here *[Name of Hospital] like just in our, my particular unit that I work in and generally in nursing Australia-wide I think it is there [referring to bullying in the workplace], it's awful, I wish it wasn't but I think it is there to a degree and it's I don't know how you overcome that bullying and harassment. (P25)

Another participant spoke of the culture of perioperative nurses “eating their young” and the problems of witnessing such events:

I feel that people who abuse, abuse is the wrong word but abuse new staff and don't treat them correctly as another professional person is wrong. They're a professional they should be given the same courtesy as someone who's got 20 years experience and you know you can learn from someone with just one days experience just as much as you can from someone with 20 years experience ... I think there's a real culture in theatre towards the young [younger perioperative nurses]. I don't know where it comes from ... I really don't because it's very ingrained here at the *[Name of Hospital] ... I try not to think about it too much because I get upset ... I do try little tactics so that it doesn't happen but the behaviour that you see [overwhelming sigh], oh you know that's only so and so [a younger nurse]. You can't treat them like an idiot ... you know those sorts of things really upset me it's that culture. (P29)

The earlier study by Michael (2001) also identified perioperative nurses being ignored, “humiliated in front of other staff and patients” experiencing “horizontal violence” and “unprofessional attitudes” (p. 13). Other authors also identified that bullying occurred in response to the stress and nature of the work environment (Dunn, 2003; Gillespie, Wallis & Chaboyer, 2008; Gilmour & Hamlin, 2003; Kingdon & Halvorsen, 2006; Michael & Jenkins, 2001a, 2001b).

In this current study, several participants spoke of *the operating room work culture* as exacerbating various management leadership styles that were unsupportive of their ability to action a conscientious objection to participating in procurement procedures. This further devalued their rights and exacerbated the need for them to hide their beliefs about their participation choices: “If you had a conscientious objection you should be able to ... sort of voice that and not be ... dismissed as it's irrelevant” (P13). Another participant spoke of feeling devalued as a perioperative nurse when she witnessed another nurse being

discriminated against while exercising her rights to a conscientious objection. The participant provided the following analogy:

Okay, theatre is our specialty but I think [being devalued] its part of the nursing, the culture. It happened when the nurse refused to participate ... I don't know if you have ever heard of it or witnessed it but you know like there's chickens or chooks if there's a diseased chook in the pack or the flock the other chooks will get it and they will peck it, they'll peck it to death ... Well it can be a bit like that if you say you don't want to participate, they did this to the young nurse who refused to participate, it's bullying, it's harassment, [and] it's shocking.(P25)

Other participants also reported a culture of feeling devalued by members of their own surgical team further exacerbating their problem of *hiding behind a mask*. These participants spoke of being ordered about by the procurement surgeons throughout the procedure: "They [the surgeons] were part of the team and to be honest they were like the leaders of the team. ... you know they just used to order us about" (P23). Another participant who had previously worked in a regional area also reported that she felt devalued by other members of the team during a procurement procedure:

Nowadays they are a little better, I think there's more, there's a bigger push now a days to keep everyone on an even keel, be polite, be this, be that whereas in the past they [procurement teams] used to just walk in and ... and walk back out and treat you like the country hicks sort of thing. (P29)

Differing perceptions of teamwork roles were also identified in the literature. The Canadian study by Lingard, Reznick, Devito and Espin (2002) revealed that surgeons and nurses held conflicting perceptions of their health care team roles and tried to dominate their rival positions.

4.3.3 Non disclosure about the procurement procedure

The third component of *work conditions* was identified as *non disclosure about the procurement procedure* by perioperative nurses. Some nurses reported that as a result of *working behind closed doors* several participants felt constrained to voice and promote organ procurement and transplantation. Participants articulated that they had learned to not talk about what happens in the operating room and what they do with anyone outside of the work environment. A major reason conveyed by the participants was their sense of professional duty and responsibility to protect the public, their own families and the families of donors and other allied health professionals of the traumatic aspects of the procurement process which they have to contend with on a regular basis. Participants explained that they also wanted to remain neutral by not disclosing their own traumatic experiences as this may hamper donation efforts which they were mindful of. In addition, although participants revealed that while they did not promote organ procurement in their daily lives there was a general perception that because they were health professionals they were supportive of organ donation and procurement. In reality, participants were divided on their views regarding organ donation and procurement but kept these views to

themselves. For several participants within this study, their sense of duty led to hiding their negative experiences which reinforced the basic social psychological problem of *hiding behind a mask*.

Due to the differing beliefs regarding organ donation and procurement some participants found it difficult to promote procurement when asked about the procedure and felt overwhelmed by their negative participation experiences. Consequently, they turned these feelings inwards and suppressed their negative experiences and choose not to talk about procurement or voice their attitudes or opinions to others. Other *participants* disclosed that on a professional level it was necessary for them to remain neutral by hiding particular procedural details so as not to influence other people's intentions to donate: "They [multi-organ procurement surgical procedures] are too graphic ... I would try and not be too graphic" (P15); "I think it would put a lot of people off, to be honest. I think it's a little bit macabre [the procedure]" (P4); "I do not want to put people off" (P2); "I don't want to influence potential donors" (26).

In their isolated work environments perioperative nurses were often unaware of how much information was given to family members in regards to procurement surgical procedures by other health professionals. Although, perioperative nurses had limited contact with the families of donors they explained that if they were asked specific questions by these families they would not know how to respond. Several participants explained that they were uninformed and lacked knowledge of how much information is disclosed to the donors' relatives : "I have absolutely no idea when relatives are approached about organ donation how much they are told about what goes on [in theatre] ... therefore it's hard to know how much you should tell them" (P4). These situations therefore influenced several participants to *non disclosure about the procurement procedure*.

Other participants disclosed that if they were asked about organ donation by donor families or the general public they tried to portray procurement surgery as a pleasant procedure and did not disclose any graphic procedural details which could cause distress. One participant explained: "I've made it [the procurement procedure as] very pleasant. You are dead, you are pronounced dead ... you are definitely dead all of that ... an honest tale ... I don't want to influence them [on] whether they want to be a donor or not" (P30). This viewpoint was shared by another participant:

If they were making a decision on organ donation ... I think it would depend [on] who it was ... it would be worthwhile letting them know what happens but then I would hate to also put someone off donating organs because it sounds a bit gross. (P18)

Often nurses could not come to terms with their own participation experiences and they found it difficult to articulate this information to others such as to the family members of donor patients. Participants felt it better to not disclose information that would otherwise cause distress and their non disclosure was another form of *hiding behind a mask*. This was exemplified by the following participant's response:

The thing is do the family want to know all these things you know I think that's the question we must ask [ourselves is] do the family want to know, you know what ... was happening to their loved one, quite often we do the incision, it is quite a large one of course and everything is exposed. I mean, I for one wouldn't want to know that is happening to my loved one. The fact that they are going into theatre and they are going to be treated like that [participant referring to the incision and removal of organs] ... I think that would be all that most people would want to know. (P20)

Commonly, the nurses focused on providing procedural information, explanations of the respectful care that would be provided to the donor and their family member within the operating room, and the benefits of the procurement of organs to saving numerous lives:

If they had specific questions [about procurement surgery] I wouldn't go in depth if they were just sort of asking would I have it done [be a multi-organ donor]. I would just tell them that you know the whole [surgical] team is very, very respectful and does look after the deceased person [the donor] and just let them know, reassure them that their family or themselves would be taken care of and the outcomes of that would be saving potentially numerous lives. (P12)

In *hiding behind a mask* participants continued to inhibit any graphic and confronting discussions that were about procedural matters as it was ingrained in their minds that they were protecting others from the distressing and negative aspects of the procurement process:

I would be very careful about how much information I shared especially with people with no medical knowledge because you run the risk of putting them off [donating organs]. I would never consider doing that and I would try again and focus on the positive [aspects of donation]. You know of course I wouldn't go into detail [about the procedure], I'd skip over it, I'd probably impart a little bit [of information] but I would be very selective in what I said. I think it would put them off and it might influence their decision to actually donate [organs] if you went into great detail about what happened and everything else [which occurs in the operating room]. I think it would put people off. (P13)

Non disclosure of information was also identified by other researchers where nurses were identified as being neutral towards organ donation requests and avoiding initiating talks about the donation or procurement process with the donor's family for fear of causing them further distress (Elding & Scholes, 2005; Kim et al., 2004b). A phenomenographic study by Floden and Forsberg (2009) investigated nine Swedish ICU nurses' attitudes towards organ donation and the care of potential donors and the nurses reported that it was important for them to remain neutral so as not to influence the families' decision on organ donation. An earlier study by Sque, Payne and Vlachonikolis (2000) also looked at the attitudes, knowledge and behaviours of 2465 nurses in the United Kingdom using a questionnaire on cadaveric donotransplantations. Similarly, these authors validated that some nurses believed that they did not have a moral or professional obligation to facilitate

donation or discuss aspects of donation with bereaved families as it was thought to be too distressing.

In the current study, participants held fears that if they were not advocating procurement procedures then other allied health professionals would express disapproval towards them and their views. They reported that other specialties such as ICU nurses and critical care nurses were unaware of their experiences and what they witnessed as perioperative nurses working within these procedures. Participants reported it was easier not to talk about their experiences or roles. While this increased their levels of *hiding behind a mask* it was vital for them to suppress these beliefs and manage their experiences.

Several participants struggled with their own conscience and held fears stating that they were not always completely honest when providing information to other people about being an organ donor as they believed it was not their role to divulge such information about the procurement process: “If it was just a member of the public I don’t feel that is really my role to go into too much detail” (P15). A similar response was provided by another participant who was very matter of fact with the following view:

Touch wood ... nobody has ever asked me but I doubt if I would go into specifics. I would just tell them that the patient comes and they have their operation like everybody else, they are treated exactly the same way as people who are going in for [elective] operations but in this instance we just take the organs that they had asked or requested to take and they do it in a very professional and caring manner ... that is exactly what they do ... in a very clinical and very sterile sort of environment. (P20)

Another participant provided a similar account: “It depends on how hard they push me. I’d say I don’t really think you need to know that or why do you want to know that and try and talk around it” (P29). Participants reported being selective regarding who they would disclose procedural information to. However, these same nurses disclosed that they would maintain *hiding behind a mask* by not disclosing to the public the same information which they conveyed to their own family. They would direct members of the public to where they could access further information as they felt that it was not their role to advocate the procedure. Many participants commented that they would disclose with honesty information to their family and close friends but would be guarded if required to disclose the same information to a member of the public. These nurses were also concerned that the information they did disclose may be misinterpreted and cause people in the general public to come to the wrong conclusions about what was happening to their relatives:

When you are talking to a lay person with a lot of that stuff [information about organ donation and procurement] they don’t have the training [or medical knowledge], they don’t have that clinical way of looking at it but if you were talking to another nurse they’d understand ... [there’s] a presumed [knowledge] that they have and an understanding ... because [the procedure] it is a bit off putting ... they [the public] wouldn’t really be understanding [of] what you were talking about ... they would come to the wrong conclusions themselves as to what happens. (P18)

Some perioperative nurses' refused to answer any questions in relation to the procurement procedure or what care is provided to donors' within the operative environment to anyone by making the following statement: "If they [referring to people in the general public] come forward and wanted to know exactly what happened in theatre I wouldn't let them know" (P16). Some participants experienced the surfacing of doubts as to whether they were right in not fully disclosing such information as it went against people making an informed decision. Others held the view that people were responsible for seeking out their own information but also held similar doubts and kept these hidden:

I think that they're adults and they don't need to know this side of it, our side of it they just need to know whether they want to be a donor or not. They can search for their own reasons. It's just not telling. It's not actually; you're not being dishonest is it? I guess they don't need to know the details because that's our job, that's what we do. (P30)

Some participants felt extremely burdened by the problem of *hiding behind a mask* and the need to hide information about the procurement process. These nurses' felt that they were being dishonest when they did not provide people with the information they requested:

I do tend to try and protect most people from the goriness of theatre, so I wouldn't just describe it [the procedure in detail]. I find that very difficult ... for me it is really the lack of honesty about what the donor [goes through surgically] and what happens [during the procedure]. (P26)

Similar doubts were experienced by a participant in the study by Kim et al. (2004a) who stated: "The donor families don't know the whole organ procurement process, but if they could see the organ procurement... well, they would regret what they did..." (p. 303).

In the current study, a few participants struggled with, non disclosure about the multi-organ procedure as it was too much to bear and they felt they had a moral obligation to disclose and protect their own loved ones from the procedure and not recommend the procedure to family and certain friends.

For my family ... I feel as if I could be honest with them, very close friends again there are some who I, I probably would say to them this is where you can find more information and kind of put them towards you know the website [organ donation] that kind of thing ... I think some people don't want to know too much information but if it was just a member of the public I don't feel that is really my role to go into too much detail. (P15)

4.3.4 Waiting for procurement surgery

Waiting for procurement surgery was identified as the fourth component of *work conditions* which influenced the participant's experiences of *hiding behind a mask*. Participants recalled situations where their experiences of *hiding behind a mask* intensified as a result of *waiting for procurement surgery* to start. The scheduling of procurement was also a critical factor as most of these procedures were undertaken in the early hours of the morning

when there were limited staff available in the operating room to undertake these procedures. This impacted heavily on participants who had to accommodate the extra workload with little or no time to recover in between surgical procedures. Participants reported that these situations added to their increased stress levels with pressures to complete the surgery they were already involved in at the time, not allowing them time to prepare and be ready for the upcoming procurement procedure:

I was on nights and then these [procurement] cases always come in the middle of the night ... we got a phone call saying that we [will have] ... a procurement [procedure] and it involved different things and hospitals like the people from *[Name of Hospital], we were getting heart, lungs and it's like wow [we were] getting everything sorted and we still had cases on that night. So it's just making time for that [procurement procedure] ... Well, we just do it [slot it in], like after we finish our list [of scheduled surgeries] and then get ready to get the [donor] patient over [to theatre]. (P35)

Participants also reported experiencing elevated levels of anxiety and stress prior to the surgery commencing as they had to wait for procurement teams to arrive at the donors' hospital. The longer they had to wait, the greater the sense of panic and anxiety they experienced particularly those who lacked previous exposure and experience in this area. Often these participants had to contain and hide their pent up anxiety for long periods of time until the teams arrived while managing their existing workload:

Usually, we get a phone call, whoever's [is] running the floor in the theatres will get the phone call from the doctors from ICU to say that there's a procurement, a patient for an organ procurement and then they contact the retrieval team, and for us here in *[Hospital location] they come up from *[location] ... they try to give us an ETA [estimated time of arrival] ... their arrival time and nearly all the ones that we've done it's always in the wee [early] hours of the morning or late in the evening. It's never in the middle of the day it's always [in the early hours of the morning], because they [the external procurement teams] have got to fly up and get organized. So then it's a matter of waiting for the [procurement] teams to arrive. (P25)

According to an earlier study by Hibbert (1995) nurses also reported the waiting for procurement teams to arrive and the procedure to commence as "unbearable" and "endless" (p. 403). Within this current study participants reported experiencing frequent delays in the commencement of procurement procedures. This occurred due to things such as the availability of certain procurement professionals or being delayed at airports due to bad weather conditions: "Sometimes they [procurement teams are delayed], they have hiccups, bad weather, the plane can't leave, the retrieval teams for whatever reason you know gathering [the team] together you know things like that ... we usually wait until they arrive" (P25). A similar experience was also reported by another participant:

One night we had a really bad storm and they were talking about how they were going to get out [fly to the hospital] because they had grounded the flights you know ... and so they had to hire a special plane or something you know, it's a lot of a travel and it's a lot work. (P29)

Another issue was how far procurement teams had to travel to get to the donors' hospital location which led to extending the waiting times for the nurses allocated to participate in these surgical procedures. This was most apparent for staff working in regional and rural areas:

I think the distance is probably the big thing for us and the fact that you're waiting so long for teams to come. It can be ... very difficult because you know that ... we might know at 4pm that afternoon, we know it's not going to be 'til after midnight [when we start the procedure]. So you know you've got that factor, 'cause it's [the surgery is] never, it's never usually before midnight. It's usually between midnight and 2 o'clock before the [procurement] teams arrive. (P28)

Once the hospital had been notified that a procurement procedure would occur participants who were working an on call shift explained that they were not allowed to leave their work environment or go home and have a short break whilst waiting for procurement teams to arrive. This situation led to these nurses working extended hours into the early morning: "The timing for them to start [the procurement procedure] is difficult like a lot of the time we are waiting, a lot of times we were operating in the middle of the night" (P35). Furthermore, being overworked and fatigued predisposed these nurses to further increases in their levels of stress and in their ability to cope with the impending surgery as described by one nurse who worked in a rural region:

Here you tend to have a long wait ... before you know that the surgery is going to actually take place, before the [procurement surgical] teams can be flown up and everything, so you've got a long wait which can be an element of stress sometimes if you sort of have to wait, especially if you know it's going to be in the early morning which quite often it is up here at *[Hospital location]. (P28)

In summary, *work conditions* encompassed five components which were reported as compounding the nurses' ability to cope with their professional work roles and the demands of procurement surgery thereby influencing their experiences of *hiding behind a mask*. *Working behind closed doors* perioperative nurses were socially and physically isolated, often working hidden and unacknowledged from people in the public and other nursing specialties. The participants explained that as a result of their work being hidden that this contributed to the *devaluing of the perioperative nursing role*. Several participants also found it difficult to talk about organ donation and what happens to donors throughout the surgical procedure. Therefore participants had a need to *non disclosure about the procedure* as they did not want to be responsible for causing distress to others. Participants also experienced increased levels of stress and anxiety whilst *waiting for procurement surgery* to commence and the *impact of increased workloads* compounded their experiences causing lingering resentment towards their participation because they felt overworked and undervalued.

4.4 Levels of knowledge and experience

The second condition influencing the study participants' experience of *hiding behind a mask* was their levels of knowledge *and* experience in procurement surgical procedures. Four components of *levels of knowledge and experience* were identified: 1) *participants' prior experience and exposure to procurement*; 2) *lacking professional development opportunities*; 3) *lacking education resources* and 4) *limited mentoring opportunities* (See Figure 4.3). This increased their *levels of hiding behind a mask* as it was vital to conceal their lack of knowledge and experience in order to participate in the scheduled procedure. Participants commonly were hiding their *levels of knowledge and experience* from other members of the surgical team and from their fellow nursing colleagues which was another facet of *hiding behind the mask*.

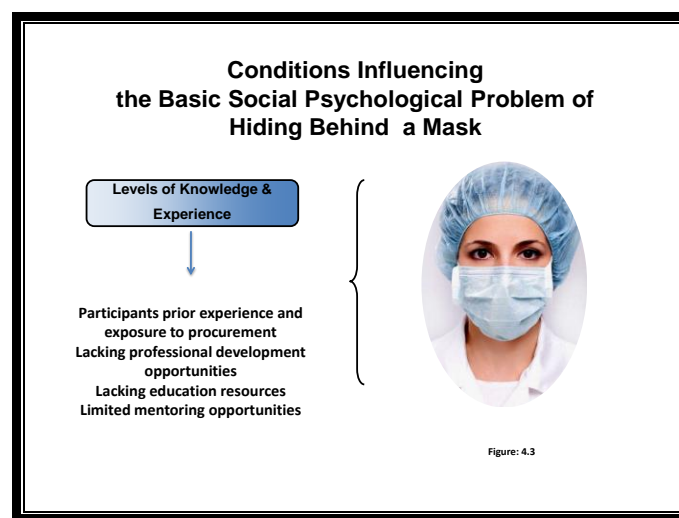


Figure 4.3: The components of levels of knowledge and experience

4.4.1 Participants' prior experience and exposure to procurement surgery

Participants' prior experience and exposure to procurement surgery was the first component of levels of *knowledge and experience* which impacted on the perioperative nurse participants' experience of *hiding behind a mask*. Several participants in this study reported not having any preparation through *prior exposure to procurement surgery* at the time of their first participation and as a result felt unprepared and overwhelmed when they were required to assist: "It could happen [the procurement procedure] at any time ... within your perioperative nursing career" (P24).

Several participants reported that procurement procedures were viewed as difficult procedures to master for inexperienced or junior perioperative nursing staff: "It's only very junior [and] new staff ... it takes them a long time to get it [the technical aspects of the surgery] and then the light comes on [they gain understanding of the procurement process]" (P4). The majority of participants expressed the view that some years of post registration experience within the perioperative nursing setting was essential prior to undertaking such procedures. The younger or less experienced nurses' found procurement

more difficult to grasp when they lacked experience or exposure which only further exacerbated their ability to cope, feeling out of their depth, which added to their stress reactions and negative experiences. This view was shared by several perioperative nurses with one nurse stating: “I think it would be very difficult for nurses with limited theatre experience to cope with, they would probably need a greater level of support and preparation to be involved in those cases” (P13).

Having no prior experience and exposure to procurement surgery predisposed several perioperative nurses to feel overwhelmed by their lack of preparation for their initial participation: “I was overwhelmed, like “my god what am I doing?”(P16). Another participant gave this perspective: “I wasn’t really prepared for participation in procurement” (P22); “being so inexperienced ... you get overwhelmed” (P9). Participants spoke of feeling out of their depths due to their inexperience: “I had fairly limited ... it was a brief experience [in procurement]” (P11).

Several participants reported that not all experienced perioperative nurses had exposure to organ procurement procedures especially if they had previously worked in smaller or private hospitals who were not undertaking such procedures. These participants although they may have had several years of perioperative nursing experience also reported feeling apprehensive about participating in their first procedure:

The first one that I did [participated in] here at *[Name of Hospital] ... I was really, very apprehensive, I hadn’t been involved in anything like that before and I knew that it [the procurement procedure] would one day sort of arrive [requiring my participation] and I was a bit apprehensive about going in there [to the theatre] to assist. (P2)

The same experience was reported by another more experienced perioperative nurse:

[I] never got the experience to go in [to theatre and participate in procurement surgery] and then one weekend, I was first in charge, we had a lady [donor patient] who was from *[Name of location] and we attempted to do a [DCD] organ procurement [procedure] on her but she didn’t pass away in the designated time and then a week later I was in charge again and we had a 10 year old boy who had severe head injuries [and was brain dead] ... he donated all his organs so that was [a] pretty big [procedure]. (P27)

Although these nurses were viewed as more senior this did not make their participation less traumatic: “After a long career in theatre it had a profound effect on me ... it was a tough experience for me” (P26). Other participants explained that regular exposure to these procedures was required to reinforce their knowledge and experience of the procedure as it took time to develop this knowledge and skills: “The more cases that you do the easier it gets” (P19). However as these procedures were not undertaken on a regular basis the length of time between exposure to these procedures was often drawn out thereby participants were lacking current experience and were *hiding behind a mask* when they were experiencing all the same uncertain feelings of increased stress and anxiety as if it were their first experience: “We don’t do enough [multi-organ procurement surgical

procedures]" (P16) and from another participant: "You are not doing it every day, it's that routine of not exactly knowing exactly what to do" (P7); "We don't do many here at *[Name of Hospital] so when we do have them everybody is not really quite sure what to do" (P31).

Whilst experience in these procedures was reported as important in alleviating some of the stress and anxiety of what to expect, experience itself was not always an important factor in coping with these procedures. Therefore the perception of experienced nurses being better able to cope is not necessarily true as having consecutive experiences in procurement procedures was a factor that also led to more experienced nurses *hiding behind a mask*. These participants spoke of continually being rostered to assist with these procedures while suffering their own hidden turmoil of re-exposure to procedures they may have wanted to avoid: "Sometimes there is no one else ... it's the skill mix ... I was the most experienced nurse [to assisting with the procedure] at the time" (P35); "I was the most appropriate person to scout for this procedure" (P13). These experienced nurses often wanted to object to participating in such procedures but they were placed in the position of being unable to refuse to participate due to the perception they had extensive experience and were able to cope. These unwanted experiences did little to alleviate their own personal feelings and associated trauma due to their participation.

Regardless of participants' prior levels of experience and number of times exposed to these procedures they continued to report difficulties with managing their levels of stress and anxiety when faced with assisting in further procedures. Several participants spoke of each procedure as being different and presenting them with new challenges and different experiences which always served to increase their feelings of being overwhelmed: "I think that every case is different in that you are taking different organs [from each donor]" (P12). Similarly this same viewpoint was highlighted by another participant who commented:

Everything [every procedure] is very different. We did [a multi-organ procurement surgical procedure on] this older man, he had a stroke of some sort ... it was just a different situation compared to the young boy [donor], compared to the mother [donor] who was going to have a cardiac death [DCD] retrieval so [I experienced] three very different situations [and surgical procedures]. (P27)

4.4.2 Lacking professional development opportunities

Lacking professional development opportunities was identified as the second component of *levels of knowledge and experience*, which intensified the perioperative nurses' experiencing the problem of *hiding behind a mask*. Participants within this study articulated that there was no formal education program to assist perioperative nurses to gain specialist knowledge and skills in assisting with multi-organ procurement surgical procedures. Therefore, there were no formal opportunities for professional career development and continued learning within this expanding and specialised area: "We had no formal training ... I don't think there is a lot of education" (P3); "No education at all" (P13); "None whatsoever [no education]" (P25); "Nothing formal, no workshops or anything" (P9); "We

did not have any formal teaching as such" (P3); "We are not really trained in it [procurement surgery]" (P7); "No, I can't actually recall ... any education to be honest" (P4); "No, we weren't sent away or were sat down for an in-service on what you did [when required to assist]" (P8); "No, not anything sort of formal in clear terms, no I've never had any real sort of in-service even" (P14). Another participant provided a more detailed explanation:

Well, I hadn't had any preparation for it [assisting in procurement procedure] at all and it's not really talked about or anything and no sort of in-services were given in the actual theatre [in] my experience and I'm not sure if there has been anything formally done since. (P24)

Several participants explained that they felt aggrieved that there was a general assumption that perioperative nurses did not require education or professional development in this area of perioperative nursing. In general, line managers believed that being a perioperative nurse was preparation enough to participate in organ procurement procedures as one participant explained: "It was more I have the skills to do a laparotomy therefore I have the skills to do organ retrieval because it was just another level of the [surgical] process. It's no different from doing an anterior resection" (P8). However, this was a difficult situation for more junior nurses who lacked both the experience and knowledge of the organ donation process and were rostered to assist with the procedure: "Probably my lack of knowledge is probably one of the things that I'm still working on, but being a grad [graduate nurse] my experience in that area was very minimal (P11).

Participants in the study who held staff development or educator positions also confirmed a lack of formal or informal educational programs to perioperative nursing staff on procurement procedures: "No we don't do formal teaching [for procurement]" (P2). When the researcher asked why no supported programs were available at the health service it was reported that the nurses had to rely on their perioperative nursing experience to get by or seek their own information.

Lacking professional development opportunities also impacted on participants' abilities to care for the deceased donor as they were not exposed to death regularly and therefore lacked adequate preparation to provide appropriate end of life and spiritual care to these donor patients. Furthermore, as perioperative nurses routinely did not have contact with relatives they also lacked experience and confidence in communicating with the donor's bereaved family: "I have absolutely no idea about how to deal with relatives, how they are approached about organ donation how much [information] they are told about what goes on" (P4); "There are a lot of things that happen when dealing with [bereaved] families ... outside the operating theatre that we have no understanding of" (P12).

Participants emphasised the importance of their role to the overall procurement outcome and believed that formal education should also include how to work with the donor patient; their grieving families, as well as the surgical process and the potential for emotional and personal reactions to their participation:

I think the [perioperative] nursing role needs to be looked at in so far as recognising that it's important in the way of having teams that can do it [the procurement procedure] and more education [for perioperative nursing staff] instead of it is [being viewed as] just another scrub or another scouting role because it's much bigger than that. (P18)

Another participant gave a similar account and emphasised how this additional preparation would have reduced her negative experiences towards participating in this procedure:

I think education is so important. If I'd had some [procurement] education prior to doing my first procurement surgery I would have probably found I felt a lot better about it afterwards because at least ... it was like okay so this is what it involves, I had no idea before that, no idea until I got a phone call in the middle of the night and had to come in and do it [assist in a procurement procedure] ... we need more education. (P19)

4.4.3 Lacking education resources

Lacking education resources was identified as the third component of *levels of knowledge and experience*. This lack of resources further hampered participants' ability to obtain education material and impacted on the basic social psychological problems of *hiding behind a mask*. The lack of available resources was evident within all settings in metropolitan, regional and rural areas. Although, it was perceived that nurses working in the larger metropolitan areas would have better access to education and greater opportunities for exposure to procurement procedures with training opportunities, according to participants this was not so. One participant disclosed the following statement:

Considering I've worked and spent a lot of time at two of this state's major trauma hospitals I've not once had any education on organ procurement apart from your little talk [providing a background to the study] when you came, that is the first time it has come up. I had to seek out all of my own information ... I have sought out [information] myself no, there has been no discussions beforehand [prior to the procedure], there is no discussions after and there is no in house education which is a bit of a shame. (P6)

Participants in the regional and rural regions also reported similar experiences of being unprepared as they lacked both clinical exposure to a range of complex surgical procedures such as cardiothoracic surgery as well as specialised procurement procedures: "When I've assisted in the retrieval, more like the cardiac [and] thoracic part[s] of the procedure that was new to me" (P12).

Several participants' reported that the only education they had received was about peripheral aspects of procurement surgery such as on organ donation. For example, several had attended an in-service program of thirty minutes to an hour by a state donor coordinator on organ donation: "They had given some in-services [education]" (P31); "No, just attended [an] in-service" (P32); We had ... an hour in service on it [organ donation]

(P21); “Maybe a couple of talks, maybe a clinical meeting talk or maybe a talk like what you gave us [the researcher providing an overview of organ procurement surgery] since then but not any actual study days (P18). Another younger participant spoke of having an in-service session by the donor coordinator through a post graduate course specialising in the perioperative nursing field: “No, just an in-service during the peri op course” (P21).

Several of these participants stated that although these in-service sessions provided some background information on organ donation it did little to assist them in conducting their intraoperative roles: “We only had a lady come recently [she] came and give us an in-service but that was just about saying that it [organ donation] was a good thing” (P25). This view was also reported by another perioperative nurse by the following comment:

We have had one of the donor co-ordinators come to us ... and give us a talk about their role, our role in [procurement] and talking about organ donation and the criteria for ... being able to donate organs and tissue and also ... what’s involved in their [the donor coordinators] role when they’re not actually ... involved in organ procurement ... as well as ... their promotional type work. (P15)

Another participant reported attending an in-service session on lung transplantation which was provided by a cardiothoracic surgeon at her hospital:

One of the cardiac thoracic guys came and gave us a talk about the lung transplants ... we’ve [also] had lectures from [the organ donor coordinator] as well and they were a very good team a very close knit team and ... provide a service which is quite invaluable to us here ... they seem to provide all the stuff that they need to provide and help us and all the rest of it. (P4)

Several participants felt that their experiences were ignored when attending such education sessions as the focus was not targeted to their needs. Consequently, one participant who was affected by her participation experiences in procurement surgery spoke of attending an in-service by an organ donor coordinator who had glossed over the operative procedural details in her view:

I went to, it felt like a re-education class with the donor co-ordinators where they were saying to the nurses, giving them a pep talk because they heard that negativity from the nurses was not good or they needed more positivity from nurses to encourage people to think about donation. It was just the ... same white washing propaganda this woman [the organ donor coordinator] said “You know some nurses actually think that it’s a mutilating surgery and it’s not at all!” and I just, I gagged and I said “Excuse me, I have spent my entire life in theatre and I’ve seen everything opened up and pummelled and sutured what have you seen? ... I’ve never been more traumatised by such a mutilating experience.” (P26)

The researcher then asked the participant what the reaction of the organ donor coordinator and the nurses attending the in-service session was like after she had made this statement. The participant responded:

I think they just, you know what nurses are like, you know they just pull their heads in and think oh that's a bit over the top. I don't know what they thought. But anyway I'm sure the person [organ donor coordinator] running the group [in-service] wished I had disappeared [nervous laugh]. They didn't want [to hear] that sort of thing. She [organ donor coordinator] was there to pep us all up and get us out there like little soldiers [promoting organ donation]. (P26)

As a consequence, when another in-service session was given the following year the same participant chose not to attend in fear of voicing her participation views again:

I just knew that I couldn't be there [at the in-service], I decided not to go because I knew that if I started [to talk] I would say these things and all my work mates would roll their eyes ... so I decided not to go. (P26)

As a result of *lacking education resources*, many participants spoke of seeking their own learning opportunities by reading a policy or procedure manual about organ donation and procurement surgery within their department: "We sort of had the donor coordinator information file and we had things like that in the department but we've had no formal in-services, nothing" (P13). Several of the participants referred to these manuals to ensure that they were doing the right things when participating: "I also read [the] hospital policy, reading [about] cardiac death and brain death ... [to] make sure we do the right things [when assisting in the procedure]" (P32). Similarly another participant reported referring to her hospital department theatre manual as a form of obtaining some further information prior to assisting:

I was checking the procedure manual because I had never done any [procurement surgical procedures] before so I just wanted to make sure I was a little prepared ... I had none, [no formal education] I've only read the manual ... well, I read [up] ... about cardiac death (DCD) because I didn't even realise you could do that sort of situation [procedure]. So I read a small section in the little booklet on what to do and what it all involved. (P27)

Several participants referred to these manuals when a procurement procedure was imminent. However, on the occasions they were required as a resource they found these manuals out of date and often not relevant to current practice. Out dated preference cards detailing the specific needs, for example, of surgeons also frustrated participants and hampered their efforts to prepare for the procurement procedure: "No nothing [no formal education] and even the preference cards were outdated" (P19).

Another source of education was the Australasian Donor Awareness Program (ADAPT) workshop which was reported as useful and beneficial in providing information to fill in the various gaps of knowledge that some participants were not aware of: "I went to the ADAPT

course and I went to a conference in *[Name of location] about DCD's (donation after cardiac death)" (P21). Another participant validated this by providing the following comment:

I went to the ... ADAPT workshop and they talked a lot about the brain death and the tests they do and the two doctors that do the tests and all that sort of stuff. So I wasn't aware of all that before. (P22)

However, again other participants reported that the ADAPT course was not specific enough to meet the needs, for example of perioperative nurses and their respective roles. With one participant stating: "I thought they were aimed more at the co-ordinators ... for organ co-ordinators" (P29). Similarly, another participant felt the workshop was more relevant to other nursing specialties such as ICU nurses:

I did attend a study day though, run by the ... national donor program (ADAPT). It's one they go to each state and they do it just once a year. I did go to one of those sessions but it was mostly for ICU staff, which covered the family and brain stem death testing and all that sort of thing but [there was] nothing [no specific information] for perioperative [nurses] or any sort of training basically. (P9)

Another participant disclosed a similar viewpoint stating that although the information was interesting, it was not substantial or adequate to meet the needs of perioperative nurses:

They didn't touch much on [the perioperative aspect], it was focused on more emergency nurses you know, basically what happens in ... the wards or whatever or when the patients come through from wherever. It wasn't focusing much on us in the theatre itself ... what ... we [are] supposed to do [intraoperatively] ... it focused more on critical care [nurses' role] the [donor] patient's family, what they need to do beforehand, the consent and your different types of consents for children and adults and all that sorts of stuff. I know *[Name of Nurse] went with me as well ... and we both thought it was really good, it was very, very interesting but we needed more for us in theatre. (P22)

Lacking education was highlighted in the study by Malecki and Hoffman (1987) who reported that education towards organ donation and procurement was inadequate and lacking in content. These authors claimed it ignored the nurses' feelings and their experiences of participating in procurement procedures which was also a finding of this current study. Further, lacking education was also identified by Watkinson (1995) who undertook a study of the perception and experiences of critical care nurses. Participants in this current study also emphasised that education was brief, only limited to attendance at a day's course, seminar or workshop on donation and transplantation with no emphasis on preparing perioperative nurses for the emotional aspects of participation in organ procurement surgery.

Insufficient or no education provided to health professionals on aspects of organ donation and transplantation continues to be reported in the literature as a global issue not only in the nursing arena but amongst medical and surgical groups (Collins, 2005; Floden & Forsberg, 2009; Jacoby, Crosier & Pohl, 2006; Kim et al., 2006; Meyer, Bjork & Eide, 2012). Moreover, the need for further education was emphasised in a Spanish study of 1168 health professionals by Rios, Ramirez, Rodriguez, Martinez-Alarcon, Alcaraz, Montoya and Parilla (2007) who highlighted that health professionals and personnel working in this specialised area lacked training and the ability to provide accurate information to others such as health professionals and the public. Similarly, a Portuguese study by Melo, Batista, Teixeira, Figueiredo et al. (2011) confirmed that health professionals such as physicians and nurses also lacked specific knowledge and training to act as initiators towards the organ procurement process.

4.4.4 Limited mentoring opportunities

Limited mentoring opportunities was identified as the fourth component of *levels of knowledge and experience*, and these limited opportunities compounded the perioperative nurses' ability to obtain adequate professional experience in the area of procurement surgery with practical on the job guidance. Not having regular mentoring opportunities exacerbated the participants' need to hide their lack of knowledge and experience when they were required to assist in a procedure. Within the operating room mentoring is a common practice and is undertaken during clinical exposure to different procedures. A common metaphor verbalised in the perioperative setting when participating in a surgical procedure for the first time is: "see one, do one, teach one" (P5; P24; P29). However, for procurement procedures, participants were often put in a position of having to assist with the procedure before they had received a mentoring opportunity by watching a procedure. Following their initial procedure it was a common expectation that they were then ready to provide mentoring in this area if the situation arose to other staff members.

Limited mentoring opportunities also occurred due to decreased staffing levels, a lack of experienced staff to take on the mentoring role, increased workloads and being asked to participate in procedures that did not occur regularly. The following participant talked about the strain of increased workloads and being moved to assist with a range of procedures in the theatre environment which left little time for training or mentoring in how to assist with procurement surgery:

[There] could be a bit more in the training side of things or preparation in ... multi organ [procurement procedures], but then I don't know how they would fit that [education] in you know. You do rotations in this place *[Name of Hospital] and you never get to actually spend time in your [own surgical] specialty anyway due to extra workloads ... you're constantly [working] in other [theatre specialty] areas. (P5)

Similarly, the requirement for further education and preparation for health professionals has been identified within the literature. A participant in the earlier study by Watkinson (1995) emphasised this aspect: "It really is a bit of a taboo subject, nobody talks about it

[space noted in quote] there perhaps should be a net that catches people before they are thrown into this type of care” (p. 936).

Within this study, when participants were confronted to participate in a procurement surgical procedure they often found they had limited opportunities to be mentored throughout the surgical procedure due to a lack of experienced staff available on the day these procedures presented to the operating theatre: “Yes, I was anxious and scared because nobody [the nursing team] knew what we were doing” (P31). According to an earlier descriptive survey study of perioperative nurses by Lloyd-Jones (1996) only 46.9% of the study respondents reported some form of teaching during a procurement procedure; however this was also reported likely to not occur due to lack of time and focus on the surgical procedure. In this current study, this was also evident when there were lacking staff numbers, in addition to issues of staff retention within the particular hospital operating departments: “We don’t do them [procurement procedures] very often here *[Name of Hospital] that’s probably why the people that may have been involved in them [the] last time may not even be working here anymore you know” (P18). Consequently, another participant reported that increased turnover of staff meant fewer experienced staff were available to provide mentoring towards these procedures:

No, because most of the time you find that because we have such a high turnover of staff there is always very seldom someone there that has done it before [participated in a procurement procedure] or they can really explain it [the procedure] ... you know it’s not something [a procedure] that happens all that often, you know. (P14)

Moreover within the literature, this aspect was also identified by Wang and Lin (2009) when a participant stated:

I only remembered I was taught by a rather careless senior nurse at my first organ procurement. She didn’t know what the operation needed or the operation procedures. It caused me to be the target of the doctor’s anger. (p. 280).

In this current study, a participant explained that during a procurement surgical procedure the amount of mentoring opportunities were often limited as these procedures occurred quickly and staff were intensely busy once the procedure commenced. Another participant reflected on her experience explaining that she received a quick overview of what was about to take place by a more senior nurse: “I had nothing [no education or mentoring prior] to begin with just a senior nurse who said “We’re harvesting, this is what happens and this is how it goes and this is what you need to do.” (P30). Another participant received no mentoring but learnt from observation while assisting with the procedure reinforcing the ‘see one, do one, teach one’ common principle in the operating room: “It was more [like] being involved with a couple of cases with people who had the skill base and the knowledge base anyway and you picked it up from there [watching them]” (P8). Participants reported that due to limited mentoring opportunities during organ procurement procedures they were often on their own to manage the procedure, having to

hide their lack of knowledge and get by with what they knew. This was particularly so when working with more junior staff: “You go out on your own [when participating], you know you have got nobody else to fall back on when you are working with inexperienced staff” (P23).

Participants also reported that the surgeons performing the procurement procedure were also not available to offer support and mentoring to the nurses assisting them as it was a very busy procedure. The conversations with surgeons were limited to providing intraoperative instructions and prompts of what surgical instruments were required throughout certain stages of the procurement procedure. This was noted by one participant who required some assistance with the instrumentation required at the time of opening the chest and excision of the heart and lungs:

I required mentoring [by the surgeons] especially when they took the heart and lungs as I'd never done cardiothoracic surgery. They took the saw and [the things] they would need so I had to have it ready on the table. If I'm busy they could just grab it. (P9)

Other participants explained that surgeons would provide limited mentoring of perioperative nurses only when they asked specific procedural questions although it was important to ask for this mentoring: “He will either teach you or he won't teach you it depends on your approach ... how you ask him [surgeon] ... ‘What are you doing now? I don't understand what you are doing’ ... I think that lets them know” (P21). Surgeons were also often mentoring their own junior medical colleagues during procurement procedures: “Most of them [the surgeons] are very [busy], they talk to each other more so than [they] talk to us [the perioperative nurses] and they'll explain the anatomy or something like that to each other” (P25). This experience was also encountered by another participant: “The cardiac surgeon was ... explaining the procedure to the medical student about what he was doing ... the surgeon was also teaching the junior reg [surgical registrar] as well” (P21).

These situations often impacted on the nurse's behaviour of *hiding behind a mask* and the need to not disclose their lack of knowledge or experience in this area to members of the surgical procurement team. As one participant explained she had never come across a surgeon who had asked her if she had previously participated in a procurement surgical procedure:

They [the surgeon] sort of explain things [not in-depth] ... [they will] tell you what they need [throughout the procedure]. They have usually got sort of their assistant there and I don't know whether that's someone they're sort of teaching as well. They always seem to talk to them [surgical assistant] the way through [the procedure], what they're doing so whether they've got someone with them that's learning. I've never sort of really got asked by them [the surgeon] whether, I have ever done this [procedure] before. (P28)

Mentoring opportunities, although limited were also reported to be provided by either an organ donor or transplant coordinator to some perioperative nurses as these health

professionals were often in the theatre at the time procurement procedures were being undertaken. These coordinators were usually undertaking their own professional roles such as assisting with coordinating the various necessary paperwork and packing of the organs for transportation however they still ensured they provided some levels of guidance or mentoring to the perioperative nursing staff. Participants described this mentoring as limited but helpful. However, they still expressed being guarded about their lack of knowledge and feeling anxious in conducting their roles throughout the procedure as these health professionals had other duties to contend with. Limited mentoring from the donor coordinator occurred only throughout certain stages of the procedure as she/he had their own duties to fulfil: “So we were all fairly new and most of the guidance came from the donor co-coordinator ... we had no one else but they were not always available” (P14).

In summary, *levels of knowledge and experience* were identified as the second condition influencing the participants’ experience of *hiding behind a mask*. *Levels of knowledge and experience* encompassed four components: *the participants’ prior experience and exposure to procurement surgery*; *lacking professional development opportunities* on procurement surgical procedures specific to perioperative nursing practice; *lacking education resources* and *limited mentoring opportunities* were also reported as contributing to perioperative nursing staff having opportunities to gain experience in undertaking procurement surgical procedures within busy operating rooms.

4.5 Levels of support

The third condition influencing the study participants’ experience of *hiding behind a mask* was identified as the *levels of support* provided to perioperative nurses when participating in procurement surgical procedures. How participants were supported or not was another condition which was reported to contribute to their experiences of *hiding behind a mask*. Several participants within this study reported limited or nonexistent resources for perioperative nurses to seek support. They felt they lacked support from their organisation by their nurse manager, their fellow colleagues and lastly access to professional support such as counsellors. Three components of *levels of support* were identified: 1) *lacking support within the operating room organisation*; 2) *surgical team support* and 3) *access to external professional support* (See Figure 4.4).

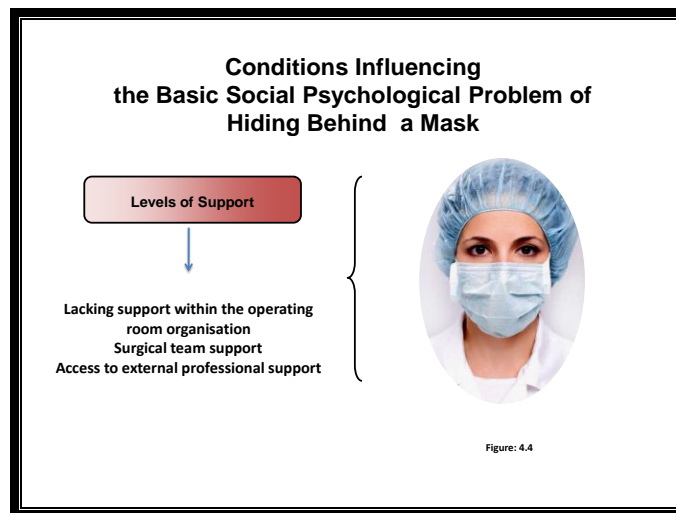


Figure 4.4: The components of levels of support

4.5.1 Lacking support within the operating room organisation

Lacking support within the operating room organisation was identified as the first component of *levels of support* within the work environment. It led them to further suppress their experiences as they had no one to talk to about the impact on them of participating in procedures such as multi-organ procurement: “People don’t talk about it their experiences afterwards ... they just carry on with their job and nobody else [other nurses or allied health professionals] understand ... you feel so isolated in here [the operating room]” (P6). Several participants spoke of the significant lack of support from their organisations, namely their direct line managers when participating in procurement surgical procedures. “I’m a little annoyed ... I don’t know how to describe it ... I just I feel they [the managers] should offer or even just ask me “are you OK? Nobody even asks after participating [in procurement surgery]” (P9). Another participant recalled:

I do recall there is a guy [a male nurse] who does mainly orthopaedics and he had done a retrieval [a procurement surgical procedure] but he was telling me a few weeks ago that he got no support or concern [about his well-being], no thank you for participating from management. (P21)

Participants articulated various incidents and situations where they felt they received little support from their organisation with the greatest oversight being made in regard to the nurse’s level of well-being and the effects of procurement surgery upon them. This was emphasised by the following participant:

No support [by management], it’s like ... the [donor] person is clean[ed] up, the theatre is cleaned, [the floor coordinator then] allocates them [the staff to another theatre] and nobody seems to know [if] there is a problem or if somebody is weeping. I don’t think they [floor coordinators/managers] even notice. (P16)

The same participant elaborated further on the resultant anguish she felt when she was not asked by management if she required some forms of support or time to deal with the effects of her participation:

I thought no one has asked me, I've participated four times in organ procurement ... I haven't been approached by the management ... whether we need any counselling or help regarding any personal issues "Are you okay, do you want a half an hour to talk about it you know?" No, we just finish [the procedure] and if we have time if its morning tea time we go to [have] our normal morning tea [break] and then come back and send for the next [patient and] case and just start another procedure. (P16)

Participants expressed that they felt unsupported when the needs of the department came before their own needs. Several participants voiced that when they were not given an opportunity to recover from their experiences of participating in a multi-organ procurement surgical procedure; they were left *hiding behind a mask*. It was common for them to be directed by the line manager to undertake other surgical procedures immediately after participating in a procurement surgical procedure. This left them with no time to recover from the emotional trauma they had experienced from participating in the prior procedure. This increased their experience of feeling devalued as a person and as a professional but they did not talk about this within the theatre environment for fear of reprisal or ridicule and withdrew into themselves by *hiding behind a mask*:

I don't feel it is appropriate, I, I don't think it is appropriate after having a death in the theatre just to rush into that [another case] ... people need to sometimes, to settle, different people react emotionally or differently. Yes I, think that we need a little bit more time we have the person who is cleaning the [donor] patient they will just send for the next case. They [floor coordinators/managers] know that the [donor] patient is still on the table and they're hurrying to start the day cases otherwise there's a delay. (P16)

Another example of this lack of awareness and support for what the nurses had just been through was that these nurses who had just been involved in the procurement process were often separated as a group at the completion of assisting in these procedures and sent to form various surgical teams to assist in other procedures. When this occurred they felt highly stressed as they had no time to talk to their colleagues and had to repress their feelings about the experiences they had just encountered to immediately fulfil current work commitments. Participants also spoke of other work commitments taking priority even when they had not completely concluded their roles in the procurement procedure. One nurse provided an upsetting account of this experience where she was not able to complete the perioperative nursing role of providing post mortem care towards the donors' body at the conclusion of the procedure:

So, that was a rather negative experience, I think because it was such a long day we didn't really know what was happening [throughout the procurement process] there wasn't a lot of support from people here at *[Name of Hospital] afterwards and I think that the most upsetting bit was at the end [of] the procedure ... we really wanted to stay and lay her [body]

out because we felt that it would help us finish [the donors journey] and give us some sort of closure but we were told to do other duties. (P18)

This lack of closure for the nurses at the end of the procurement procedure left them overwhelmed and distressed as they had to bottle up their feelings. They felt burdened with guilt when having to discontinue the care provided to the donor which occurred often midway through providing post mortem care. Some participants felt further aggrieved when they could not fulfil their work duties and obligations such as providing an appropriate level of post mortem care. When this occurred they felt they lacked the support from their organisation:

This hospital, I have to admit, I felt really cheated that we all couldn't do that together [care for the donor] and it would just have been nice so we could all care [for the donor] and we could talk about it, what we had experienced properly, cared for him [the donor] and like we said good bye to him each individually and I sort of went "Come on we've got to go into the other theatre" and we just all said good bye. (P27)

Nurses working in rural hospitals also spoke of the lack of support provided by their senior managers and other health professionals such as surgeons and anaesthetists following a procurement procedure. They were straight away placed into another team with little regard shown to them about what they had encountered in the workplace:

We finished a procurement [procedure] one evening, say about 10pm or 11pm but we still had other [emergency] cases to do. So the anaesthetists and the surgeons who were waiting were sort of like "well come on, hurry up you know I want to do my thing now [surgical procedure]". So the pressure was on us to sort of like undertake another procedure, you've done that case let's get on and do the next case. So I felt like we didn't have time to catch our breath sort of thing. (P25)

Participants also felt they lacked organisational support when they were not approached by line managers and informed of the support resources that were available to them within their organisation. This was validated by one participant's comment: "Yes, I don't know whether [long pause] I presume they [managers] are aware that you're meant to offer those sorts of debriefing or counselling sessions but I've never been offered anything" (P9). Other participants reported that when they had made attempts to request support from their line manager to access professional support from their organisations or managers the requests were often not actioned or were declined:

Yeah, well that would be huge for us [requesting support] because as I said we're in the country and our resources are limited although we can, you know sing out and say and request, we don't always get what we want. (P25)

Another participant also reported a lack of support from management directed towards staff participating in these procedures. This participant [an educator] was passionate about having timely support for her staff following their participation in procurement procedures:

You've got to have that good staff support otherwise, I find management are [or] can be obstructive I'll use the word obstructive it's the only word I could use to describe management. Contrary to what they say, they'll say something to your face but they won't deliver and I have just given up on them. (P29)

Several participants felt that not being provided with any forms of organisational support was inappropriate and that this intensified their experiences of *hiding behind a mask*. However, one participant elaborated that she felt that line managers themselves were hindered in their roles to provide such support or care to their staff:

I just don't think [long pause & sigh] that's inappropriate, in our field we're supposed to be [a] caring profession but there's nothing from management. I just think ... it's an unusual circumstance that you are faced in occasionally but management don't seem to provide support and it's not good. The people themselves that are managers are extremely nice people but their roles don't allow them to extend the caring role. (P29)

A lack of organisational support was also reported by participants when they were not provided with time to access professional support when requested. One participant felt it an injustice that she was not given time to deal with her issues and seek formal support: "It almost becomes forgotten [the experience] by moving onto something else [another surgical procedure]. There was no time to seek support ... your busy ... deal with it ... get over it and move on to something else" (P28). Some participants felt that management had a duty to allocate time for the whole team to be supported immediately after the procedure and the importance of making it happen in a busy operating room department:

I think as a whole, like from ... just our nursing manager we should have had some time allocated so we could all sit down together and have a debrief together so ... Well time slips away and you do your work, you do your routine list and you sort of, you might not see someone for a few days and then you see them and you say "Oh we should do that [debrief]" and then before you know it, a month's gone past and you think, oh well time doesn't allow it. (P27)

The same participant elaborated that with all good intentions even when there was support from management a lack of time and the ability to gather all the team together was a major barrier to this process. The same participant described her experience in trying to seek support after the whole team had participated in their hospital's first DCD procedure:

There was support from management and I did ask if we could get counselling as a group [after participating in a DCD procedure]. But at the time our senior boss she was away and we had a junior chappie [man] who was in and who was our boss at that moment and I kept on saying "we need it" and he sort of expected me to organise it but it was really hard to organise different staff when I didn't know when they were working and I just didn't have access [to their rosters] and I didn't have the time to actually stop and go, well this is where everyone is ring up the lady

[professional counsellor] and say “Well, can you please slot us in at this time”. (P27)

4.5.2 *Surgical team support*

Surgical team support was the second aspect of the third condition which exacerbated the participants’ experiences of *hiding behind a mask*. There was an acknowledgement from the study participants that they required the support from their colleagues. However, this was lacking when everyone who were part of the surgical team were *hiding behind a mask*. Several nurses emphasised that there was a need and importance to talk about their experiences: “I think you need to talk about it even with your colleagues” (P3). This was further highlighted by another participant who observed that often surgeons were also viewed as hiding their thoughts at the time of undertaking a procurement procedure on a donor child:

Sometimes I think, like even like consultants [surgeons] you know they’ve got children, who are a young child [possibly same age as donor], they are quiet sometimes ... they’re maybe even more upset than me. Everyone is closed off though, no one talks [about] it. (P23)

Another participant provided a similar account of the need for support from fellow colleagues:

I think it’s the same with the multi organ procedures and transplantation, I think it’s very distressing it can be and if you are a very sensitive person as well, well, even if you’re not it can be very distressing so I think there needs to be more support from your team. (P10)

Several participants disclosed they lacked *surgical team support* on many levels and as a result they had no one to turn to or to talk with to discuss their concerns of participating in procurement procedures. This resulted in a facade that everyone was coping and that everyone was alright. One participant reported the lack of interest of fellow colleagues talking about their experiences as: “You could see people weren’t interested [in talking] ... People were very, closed off” (P6). Similarly, talking about procurement surgery was often suppressed by more senior staff. Another participant reported wanting to talk about her experiences but this need was not reciprocated by her other team members:

I can remember on nights ... we had a particularly bad night where we had a lot of traumas and we had a retrieval. I just wanted to talk about it [the procurement] and I know ... we were told by somebody [another perioperative nurse] that “oh well that’s over and done with, we don’t need to know about it!” And you do need to talk, you need it ... you don’t want sympathy from them [your nursing colleagues] “Oh, God you’ve had such a bad night” but you just need to talk about it. (P3)

Several participants suggested that support was not forthcoming from senior nurses or their colleagues often criticised them if they required and sought support. These

participants were distressed at the lack of understanding and support provided to them. One participant provided the following account:

They were critical in things we hadn't done [during the procurement] rather than offer support. I don't know whether it was because more senior staff had their nose put out of joint because we were doing it [the procurement procedure] and they weren't or what was going on but it didn't feel like there was a lot of support coming from senior people. (P16)

Another participant encountered a similar problem with a senior staff member:

It was a senior nursing staff person at the time ... well, he was finishing work [night duty] here *[Name of Hospital] and they [the nurses] were coming onto day shift and he said "Oh well it's finished [the procurement case] I don't want to hear about it" sort of thing. (P3)

Lack of *surgical team support* also occurred when teams were formed for the procurement procedure as they consisted of nurses who may not have worked together previously mixed with people outside of the normal work environment, for example, surgeons from other hospitals. Consequently, participants were often unfamiliar with other team members and they lacked rapport and trust within the team. This increased the silence between team members and decreased their ability to disclose or seek support:

I think nurses generally are probably, if you don't know each other really well, then they won't be polite to each other and it's a human nature thing. If you don't have a tight team then you don't support each other every time. If you only know a bit about somebody, in a team people know about each other's personal life and I think that bonds them more and so then allowances are made for each other. (P23)

Some participants' experiences of *hiding behind a mask* intensified when they were told by colleagues to contain their emotions. One participant recounted this experience by having to hide her experiences, anxieties or trauma associated with her participation: "The nurses were, get out of the room if you're going to cry, you're no use to me, you know ... for them to kind of play down the event [impact of procurement procedure] they were unsupportive" (P23). Another participant disclosed that it was not worth the effort to seek support from colleagues or the surgical team as in her experience it was evident this would not be forthcoming from the participant's colleagues:

Well, that's ... what I found ... it's not worth it anymore [asking for support] from work, that's what I'm told and I think the first time I asked [for support] that was after I had done the organ procurement and it was sort of put up with it and shut up and that's it. (P19)

Some participants disclosed that seeking team support was plagued with negative connotations if they were unable to cope with the procedure. This was particularly true for senior nursing staff who hid their emotions behind their mask. Another participant

disclosed that senior nurses were provided with less support as there was an assumption that they should be able to cope due to their extensive levels of experience:

Well, because they are all a lot older ... they've see it, done it, and get on with it you know, you get very blasé and that's the thing I find the more you do or the more often exposed you actually get to certain procedures you [get] a bit cynical and hardened although some things still do upset you. The more exposure you get, you don't get any support really at all. (P19)

Some participants spoke of witnessing other nurses who were distressed and emotional during their work roles but that there was little support that could be provided to assist them due to the work environment. Several participants reported that informal support was often limited to brief rostered tea breaks. This level of support did little to assist these nurses with their own issues as they continued *hiding behind a mask*, even with their colleagues. One participant mentioned that over a coffee staff would just briefly talk about their thoughts in general about the procedure and their participation: "What did you think of that type of surgery thing [the procedure] ... it just being mentioned in general terms amongst the staff" (P11). Another participant stated: "We debrief between ourselves and sometimes that's all you need, you go and have a cup of coffee and ask [each other] how are you? Are you alright?" (P2). Another nurse recounted offering support to another nurse during a brief tea break:

I think she thought of herself as being silly or emotional and we went "no, it's not silly or emotional, you know it's how people feel"... It is not anything formal we have, we don't do anything formal we just sit and have a cup of coffee and chat about it if we were due for a tea break ... she was fine after a few days. (P2)

Some participants felt that they were not entirely part of the team feeling that their role was not as important: "You do feel like your role is not as important as perhaps everybody else's [the procurement surgical team] is certainly" (P18). The same participant emphasised that as perioperative nurses were only involved in just brief surgical encounters with procurement surgical teams there was little recognition of their roles:

You are not really a part of it [the whole process] like you are just sort of helping out a little bit [by being involved in the procurement surgical process], like a secondary aid sort of thing to what's happening. I don't know if that will ever completely change. I mean certainly it is improving within theatre, in having them recognise our role as nurses and what we do [facilitating procurement surgical procedure]. I don't know if it will ever completely change. (P18)

4.5.3 Access to external professional support

The third and last component of *levels of support* was identified as *access to external professional support* which was identified by participants to be a condition influencing their experiences of *hiding behind a mask*. Within this study, participants identified three sources

of limited *access to external professional support*. These were identified as; debriefing, counselling and support from the organ donor coordinator. Some participants were unaware of the existence of professional support resources within their respective hospitals and how they could gain access to such services. For other participants, while aware that professional support resources were available they found these services limited and often inaccessible to the perioperative nursing staff due to work commitments.

Having limited *access to external professional support* was a concern for several of the participants. These participants were *working behind the closed doors* of the operating room department, they had to contend with increased workloads and had little opportunity and contact with external health professionals to access *any external professional support resources* after they had participated in a multi-organ procurement surgical procedure. Participants disclosed that it was perceived that any external professional support was not necessary, effective or required in regards to work undertaken within the operating room specialty. One participant spoke openly about this aspect: “Counselling ... I guess because it really hasn’t been offered to us. I mean it is offered now, but I guess the value wasn’t seen I guess you were just expected to do your job you didn’t need counselling” (P30). Therefore, perioperative nurses did not have *access to professional support resources* at the time when participants felt they required assistance the most: “I don’t recall there being counselling or anything” (P11); “I haven’t had debriefing or counselling after assisting in retrievals [procurement surgery]” (P7); “We didn’t get any counselling” (P21).

Several of these participants articulated that there was a need to provide professional counselling for staff involved in procurement procedures: “We didn’t get any counselling. Well, I think we do need counselling at *[Name of Hospital] because every time we get organ retrieval, I don’t think anyone has ever had counselling” (P21). Similarly another participant stated that having access to more formal external professional support was often at the discretion of managers as they had to approve and organise it in addition to making staff available to access these services:

If they need a formal [debrief] there are channels to go through. If you felt that [it was required], and if we thought, if management thought she [a staff member] wasn’t coping either they would have gone, down more formal channels to make sure she was okay. (P2)

Another participant also reported that she had not received any forms of external professional support however she was aware that there were services available within the hospital that could be accessed:

Personally I haven’t had debriefing or counselling after assisting in retrievals [procurement surgery] but I mean the hospital does provide free counselling for anyone who wishes to use it, if you requested it. I know that not many may know of it [and] request it, but counselling is available like through *[the Name of the Service] there is no formal de-brief or anything like that in theatres here. (P7)

Several participants reported they had knowledge of where to *access external professional support* however there was nothing formal in place by their organisation where support could come to the operating room: “I know where I could access help if I wanted it, I know where I could access counselling and things like that but no I don’t think there was anything formal” (P12). Conversely, other participants were uncertain of where they could access external support and what forms of support they were entitled too. One participant felt it was important to have counselling for theatre staff but was uncertain of what was available to the specialty of theatres by the following comment:

But if people have issues I don’t know whether there is proper counselling in theatre ... I don’t think we had any support like that. The people who need counselling I think if they need it, it should be provided to them you know. (P16)

Timely *access to external professional support services* was also a concern raised by several participants. These participants spoke of the delays in getting access to external professional services some several weeks after they required this assistance. Participants reported that appointments for these services were usually booked well in advance with a 2-3 week waiting period. These appointments also needed to be scheduled outside the nurses working hours which proved difficult due to some of these nurses’ working shift work. These situations impacted on participants as they were often quite distressed requiring immediate assistance and resolution of their concerns after assisting in a procurement procedure. Therefore the timing of providing support was very important as expressed by many of the participants. It was viewed that any forms of support should be offered immediately after the procedure if they were to be effective. One participant provided the following view:

You know it’s, I think you need those sorts of things [post procedure debriefing]. It probably would have been good if something was available right when we finished, like someone was there when we finished and talked about it. But to go back and talk about it you know three days later, a week later I think that to me ... is useless. Unless you had a real problem that needed to be dealt with I think straight away. (P28)

A participant who was an educator often had nurses come to her to seek assistance as a result of staff not getting access to these professional services:

For a little while I was the educator and one of the staff needed help and I said “Righty-o we’ll ring these people and get them to help you”. There was a two week wait. I explained “they need help now, they don’t need help in two weeks time, they need help now” and that’s what I found really upsetting and I’ve spoken since to a few other people [become the support person] ... they feel they can trust me and they talk to me and I say “Well you should ring these people and have a chat to them, it’s a [professional] counselling service at the hospital ... and you give these people a ring” and you know a couple of weeks later I’ll say well “How did you go?” and the staff would come back and say “they couldn’t see me” for whatever reason. (P29)

According to Ireland, Gilchrist and Maconochie (2008) debriefing is a form of psychological “first aid” (p. 328). The benefits of accessing psychological support such as counselling and debriefing immediately after an incident has been reported as beneficial to reduce maladaptive cognitive and behavioural patterns (O’Connor & Jeavons, 2003a). Support that is provided some two to three weeks later was reported as not effective (Deahl, 2000; O’Connor & Jeavons, 2003b). This aspect was supported within the scientific literature by Watkinson’s (1995) study on critical care nurses who reported similarly that the interviewees in her study suggested that it would be useful if debriefing appointments occurred during work time and not in the nurses own time. Similarly, according to Laposa and Fullerton (2003) who investigated sources of work stress and posttraumatic stress disorder in Canadian emergency nurses reported that 67% of respondents believed “they had received inadequate support from their hospitals administration” (p. 23).

Within this current study, some participants avoided *access to external professional support resources* as they were afraid of having to disclose their experiences of *hiding behind a mask*. These participants reported that they did not want to talk about their concerns straight away opting to have some time alone to contemplate their experiences. They also needed time alone to process how they were feeling. This aspect was reported by the following participant:

I think sometimes people don’t always want to talk about things straight away ... I think we get wrapped up in task orientation [what needs to be done next] as well but we are on to the next thing that needs to happen [the next surgical case] in that ... working day that we don’t take time out to do that, to think things through. (P15)

One of the study participants disclosed that they did not require a counsellor but just needed someone to talk to such as a work colleague:

I feel that I don’t need a counsellor, I usually find that my work colleagues ... not only are they quite sympathetic but they’re quite understanding and I usually find I can relate my stories with them and they’re just more beneficial. I think it’s just even if it’s just an ear to listen. (P33)

Moreover, participants acknowledged that one of the reasons why they didn’t debrief enough was that they felt they were meant to cope and get on with their professional roles. This was done by *hiding behind a mask*. This view was reported by the following study participant:

We, probably not as much as we should do [debrief with fellow colleagues], I think that’s probably as much for any area you know, but there’s an element I suppose you just feel you should, you just get on with it [the surgical procedure of procurement] you know. It’s life and you get on with things, I mean certainly this is, certainly there are staff I think [that] could get to the point where they can’t function, I couldn’t function for a couple

of hours [after participating] you know and the other nurses must have been thinking me really callous at that time. (P23)

Other participants also disclosed that they would be afraid of attending formal debriefing as they would no longer be able to hide their feelings and would have to confront and disclose their personal issues and thoughts in a group environment. One participant explained that formal debriefing could be viewed as unhealthy when forcing participants to talk about their personal experience:

I don't know if it was a planned thing I mean you've got different personalities and I don't think ... debriefing would be [helpful], if you have a formal debriefing that would be more unhealthy 'cause I think when you, if you make it a formal debrief because they [the hospital organisation] did contemplate that, that would make it more unhealthy we did contemplate that like after the retrieval folk [nurses'] would have to go sit with somebody [to debrief]. I think then you're possibly putting somebody in a position where they have to say something, either [they] don't want to or necessarily don't want to ... [or] they actually don't feel they need to but because it's formal then maybe perhaps they surely have to say something ... you're judged as being very callous if you do not disclose some of your experiences when debriefing. (P23)

Another source of *access to professional support resources* was the debriefing work provided by the organ donor coordinator. Perioperative nurses felt comfortable talking to the organ donor coordinator but time was a problem. The organ donor coordinator also had other duties and responsibilities and would often stay with perioperative nurses on some occasions whilst caring for the donor's body however would need to leave to support the donor's family after the procedure which often left perioperative nurse with limited support. Support from the organ donor coordinator is not compulsory and often debriefing is not undertaken. However, many of the study participants validated that the primary source for debriefing was provided by the organ donor coordinator. Furthermore, the data also revealed that many of the participants were reluctant to talk about their issues in detail or in depth and were cautious and selective in whom they would talk too. One study participant reported the following:

No it was only, it was only the coordinator that was really the support ... I did think about it but it didn't distress me at all. And if I would talk to a colleague I would not probably talk to a junior staff member even if they are a good listener I think it's, you have to talk to people that have experienced it as well. So that they understand ... So I'd feel a lot more comfortable going to a work colleague than to somebody say um, a um psychologist or somebody that has no idea what the experience is like ... So I think it's really important to debrief with people that have been in the situation already themselves. Not going to support outside the hospital where they've got no idea what it's like even to be a nurse. (P24)

Another participant reported that attempts to obtain support by the organ donor coordinator were sometimes made during the surgical procedure on technical matters with personal or emotional support predominantly obtained at the conclusion of the procedure

or whilst providing post mortem care to the donor:

We do try to talk to the donor co-ordinator about it [any problems or concerns we may have] ... and in most of the [procurement] cases they sometimes they will stay and help us after the operation and we talk to [them at this time] maybe while we're laying the [donor] patient out [providing post mortem care]. (P1)

Similarly, another participant stated that the donor coordinator was another resource if they required further assistance after the surgical procedure:

Well counselling is always like ... you can and you know that it is available. The donor co-ordinators have always been there and have always said "Okay this is all my details". You know that you can contact them [coordinators] if you need too, if you need to debrief with them. (P2)

However, several participants voiced that the level of support provided by the donor coordinator wasn't adequate enough to help them fully overcome their issues or concerns. Many stated that informal debriefing or counselling in its brief form wasn't effective for nurses who had never experienced or participated in a multi-organ procurement surgical procedure previously. This was emphasised by one participant: "I didn't feel that the counselling or debriefing afterwards was enough for people that have never ever had experienced that before [the procurement procedure]" (P19).

Other participants also highlighted that informal peer debriefing also took place whilst providing donor post mortem care. However, several participants explained that the care of the donor was always the first priority before the needs of the nurse. Therefore, informal debriefing and the needs of the study participants was often neglected until after the care of the donor had taken place. These situations often put nurses in a position to not speak out as it was viewed as disrespectful to the donor. Another issue with these situations was the perception that nurses and peers were not trained to debrief each other thereby lacking experience in this area and not being of benefit to the nurses:

I think we have always been more focused on caring for the donor at the time. I think debriefing is probably something that we are particularly bad at doing and I think debriefing is something that takes a lot of experience. If you are not somebody who has been trained in debriefing I think it's a very difficult process to actually conduct that [with your colleagues]. (P15)

In summary, *levels of support* was identified as the third condition influencing the participants' experience of *hiding behind a mask*. *Levels of support* encompassed three components: participants reflected that there was *lacking support within the operating room organisation*; in addition to limited *surgical team support* during and after a procurement surgical procedure. Lastly, participants reported problems experienced with *access to external professional support* as a result of lacking knowledge of what service were available to them as a health professional in addition to experiencing various barriers to obtaining timely access to these services.

4.6 Summary

This chapter presented the conditions which were identified as influencing the perioperative nurses experiences of the basic social psychological problem of *hiding behind a mask* when participating in multi-organ procurement surgical procedures. Three conditions influenced the perioperative nurses' experience of the problem of *hiding behind a mask* these were identified as: *work conditions*; *levels of knowledge and experience* and *levels of support*. *Work conditions* were identified as the first influencing condition which encompassed the participants socially isolating work environment when *working behind closed doors and the culture of the operating room* which predisposed participants to resort to the behaviour of *hiding behind a mask*. Participants also reported it easiest not to disclose the more graphic procedural aspects about the procurement procedure in order to protect the donor's relatives and the public from procedural information which they may not understand and may cause distress. They also spoke of experiencing increased stress and anxiety whilst *waiting for procurement surgery* to commence when having to wait for procurement teams to arrive. *Levels of knowledge and experience* was identified as the second influencing condition and was recognised as influencing participant's ability to be prepared and cope with procurement procedures. Participants articulated that there were *lacking professional development opportunities* and, *lacking education resources* in addition to *limited mentoring opportunities* for nurses to gain further experience in procurement surgery. The third and last, condition influencing the study participants' experience of *hiding behind a mask* was identified as *levels of support*. Participants described that there was *lacking organisational support* and *lacking surgical team support* from their peers, and limited *access to external professional support* available to them to manage their experiences in these surgical procedures.

CHAPTER 5

The Basic Social Psychological Process: Finding Meaning

“Their continual resolving is the core variable. It is the prime mover of most of the behaviour seen and talked about in a substantive area. It is what is going on! It emerges as the overriding pattern” (Glaser, 1998, p. 115)

5.1 Introduction

This chapter presents the basic social psychological process of *finding meaning* that was used by participants to overcome the basic social psychological problem of *hiding behind a mask*. Glaser (1978) described that the basic social psychological process or core category has two or more stages and “gives the feeling of process, change, and movement over time” (Glaser, 1978, p.97). It was identified from the data that participants engaged in two processes, the first was described as the turning point which was labelled as *taking control*. Participant’s reached the turning point of *taking control* prior to engaging in the basic social psychological process, through three distinct stages which was identified as *finding meaning*. These stages were 1) *pushing through*; 2) *preserving self* and 3) *coming to terms*. Participants moved through each stage to manage their experience of *hiding behind a mask* in order to find meaning in their professional roles as a perioperative nurse and their experiences when participating in procurement procedures.

5.2 The turning point: Taking control

Within this study, participants firstly needed to reach the turning point which was labelled as *taking control* before they could move into the basic social psychological process of *finding meaning*. To place taking control into context a definition and interpretation was sought from the Australian Concise Oxford Dictionary. To “take” was defined as to “lay hold of” ... “get into ones hands” (Moore, 2009, p. 1469). “Control” was defined as “the power of directing” and the “the power of restraining” (Moore, 2009, p. 303). For several participants reaching the turning point of *taking control* was a necessary step in modifying their behaviour. As participants often had no way out of participating in organ procurement procedures they were forced to reach the turning point which was labelled as *taking control*. The turning point of *taking control* was described from the data as participants taking control of their internal turmoil and rationalising the situations they were placed in as having to participate in the procurement procedures: “I had to take control of the situation I was placed in” (P24). This process encompassed changes in their attitudes and thoughts towards their participation: “My attitudes and views gradually changed as a result of my participation” (P6). For some participants, they used an internal mantra to put their participation in perspective: “I mean we’ve all got to die and if something good can come from it I think it’s great” (P28). Other participants articulated focusing on the donor and their decisions to be an organ donor as the primary focus in *finding meaning*: “This is what he [the donor] consented for so” (P35). Similarly another participant conveyed the following thoughts: “It’s their [the donors] decision ... I think we should respect their decision [to be an organ donor] ... we should respect their wishes” (P33). In reaching the

turning point of *taking control*, participants established a shift in their views of the importance of their participation in a donor's procedure: "I think it's quite an honourable thing to do because you are respecting people's wishes" (P10); "I could see the benefits ... in extending other people's lives" (P6). Once participants were able to experience the turning point of *taking control* (see Figure 5.1) they were able to move into the process of *finding meaning*.



Figure 5.1: The turning point: Taking control

5.3 Finding meaning

The basic social psychological process of *finding meaning* emerged from the data and it was found to be used by the perioperative nurses to resolve the problem of *hiding behind a mask* when participating in multi-organ procurement procedures. As participants were clearly hiding their experiences of their participation in procurement surgery by *hiding behind a mask* there was little overt acknowledgement of the problem. For most of the participants this was a solitary and private activity, hidden and an internal process. For several participants *finding meaning* resulted from a cognitive shift in their way of thinking and they made attempts to gain some understanding and insight from their experiences. In *finding meaning*, participants moved from a state of uncertainty, turmoil and confusion to one of peace and acceptance with their role as a perioperative nurse participating in procurement procedures. This movement was reflected by one participant: "There's a person [donor] with organs ... it was always an emotional ... it was always a terminal thing [the donor was deceased] ... you try to rationalise I suppose this was a good thing coming from something awful" (P20).

A definition and interpretation of *finding meaning* was sought from the dictionary to assist with placing the theory into context. To "find" as defined in the Australian Concise Oxford Dictionary was "to become aware of, regard or discover from experience" (Moore, 2009, p. 525). Further, "finding" was defined as "a conclusion by an inquiry" (Moore, 2009, p. 525). To "mean" was to "design or destine for a purpose"... "have as a motive in explanation" (Moore, 2009, p. 881). Further, "meaning" was defined as "what is meant by a word, action,

idea ... significance ... importance" (Moore, 2009, p. 881). The above definitions were all consistent with the descriptions provided by the participants within the context of this study.

Several participants articulated *finding meaning* from their experiences when participating in procurement surgery. For some participants *finding meaning* was focusing on the positive aspects of these surgical procedures and experiencing a change in his or her own internal thoughts and attitudes in relation to life and death:

I just kept trying to focus all the time while it [the procurement surgical procedure] was going on, on the positives of the outcome of what we were doing and I think that's what basically, what got me through [the procedure] and I had to keep focusing on that certainly for the first couple that I was involved with ... and even now to some extent ... you just have to think, I personally think ... this [donating organs] is a good thing it's for the benefit of others and it's great that this person [the donor] is giving something back so I try and focus on the positive. (P13)

Other participants provided examples consistent of *finding meaning*: "That these organs were going off to be transplanted to give somebody else a better opportunity at life" (P13); "Obviously that's what the family wants to happen so you have to obviously respect peoples' wishes and beliefs" (P10); "It's something that they [the donor] actually chose and it's not a decision that we've made for them" (P12); "We are carrying out the wishes, of the donor and the family and knowing that what your involved in is helping so many other people ... it gives me a sense of pride in my work" (P15); "His [the donors] death hasn't been in vain if you can look at it like that and they will it will go on now they will benefit somebody else's" (P20); "We've all got to die and if something good can come from it I think it's great" (P28).

The identified basic social psychological process of finding *meaning* was comprised of three stages: 1) *pushing through*; 2) *preserving self* and 3) *coming to terms* (See Figure 5.2). Passage through each stage was sequential with the majority of the participants moving through all of the stages at the time of being interviewed for this study. The process of *finding meaning* for participants was not dependent on the number of times they had experienced a procurement surgical procedure therefore the participants' experiences of *finding meaning* varied in intensity and frequency. Although many participants had several years of experience as perioperative nurses, their participation in multi-organ procurement surgery remained problematic as each new experience and exposure was different for them. Therefore, participants were constantly in a cycle of *finding meaning* when confronted by each new donor patient. *Finding meaning* was also noted as difficult for participants when they were caring for younger donors who had lost their lives so early. *Finding meaning* towards these donors' deaths and participation was a little more difficult to accept in such circumstances: "It was a child ... a little boy ... it's hard to understand why this life would be cut so short" (P29).

In addition, not all participants at the time of being interviewed for this study had come to terms with their role in these procedures and had not moved through all stages of the basic social psychological process of *finding meaning*: “Unfortunately, not everybody can cope with these [procurement] procedures and not everybody should. It’s hard for some people to come to terms with assisting in these cases” (P24). Unfortunately, a few of the participants could not move beyond stage two of the basic social psychological process “I must say it’s a multi layered reason why ... reasons why I don’t want to participate in that. I won’t ever participate in a harvest and I won’t be an organ donor” (P26) and could therefore not move through the process of *finding meaning* when data was collected for this study. At the time of being interviewed for this study some participants were not yet engaged in the final stage of the process of finding meaning: “There is a huge assumption that because you are nurses you must agree with it [multi-organ procurement surgery] and I’m probably the exception to the rule because I personally don’t” (P10). Another participant could not find meaning in the loss of the donor’s life and society’s attitude to death by the following viewpoint:

The other thing that I think is that we have this terrible attitude to death in our society. We can’t accept death, no one should die, our children shouldn’t die, our parents shouldn’t die even if you are 88 years old you should have to have everything done to you so [as] to keep you alive. And I just think we have to have a more realistic view of death, but that’s not very likely I guess. (P26)



Figure 5.2: Stages of the basic social psychological process: finding meaning

5.4 Stage 1: Pushing through

The first stage of the basic social psychological process of *finding meaning* was conceptualised as *pushing through*. In an attempt to overcome the shared basic social psychological problem of *hiding behind a mask*, participants implemented strategies to overcome and alter their experiences and behaviours when having to participate in procurement surgery. For many of the study participants *pushing through* was articulated as applying themselves, fully focused on the task of assisting in the surgical process to its

completion. In *pushing through* they dissociated themselves from their internal feelings and conflicts by focusing on the importance of their role and professional contributions towards the surgical procedure. *Pushing through* was therefore one of the strategies used by participants to overcome their experiences and hence find meaning from their participation in procurement surgery and the donors in their care. Two aspects of *pushing through* were identified: 1) *getting the job done* and 2) *suppressing hidden thoughts and feelings* (See Figure 5.3).

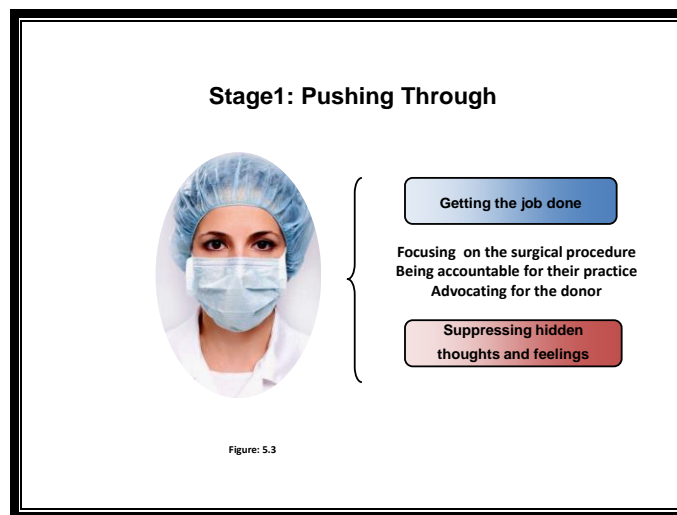


Figure 5.3: The aspects and components of pushing through

5.4.1 *Getting the job done*

Getting the job done was the first aspect identified by the researcher of *pushing through*. This was a process where participants solely focused on *getting the job done* through firstly focusing on the surgical procedure, their professional roles and responsibilities and advocating for the donor when they were participating in procurement surgical procedures. Participants articulated *finding meaning* in their work and participation by focusing on *getting the job done* which was identified to have three components: 1) *focusing on the surgical procedure*; 2) *being accountable for their practice* and 3) *advocating for the donor*.

5.4.1.1 *Focusing on the surgical procedure*

Focusing on the surgical procedure was identified as the first component of *getting the job done*. Participants in an attempt to resolve the problems experienced by their participation in procurement surgical procedures engaged in the process of *focusing on the surgical procedure*. Some participants referred to this period as taking a clinical approach to their roles: "I guess I've got a clinical approach to the whole thing ... but it's just a job to me" (P7). This period also saw participants taking control of their respective roles and the surgical situation by choosing to focus on the surgical procedure with an unrelenting commitment to providing the best care possible to donors. Participants explained that they tried to ensure that the procurement teams had everything they required to conduct the

procurement surgical procedure successfully: “I didn’t want to stuff it up [the organs being procured successfully]” (P21).

By *focusing on the surgical procedure*, several participants articulated compartmentalising or isolating the emotional aspects of their work such as suppressing their inner thoughts, attitudes and feelings towards the reality of what they were participating in: “I try and block things out [during the procedure] and just concentrate [on the surgical procedure]” (P29). Compartmentalising assisted the participants to break down their duties into various stages and tasks whilst remaining focused on *getting the job done*: “So, I do tend to compartmentalise things. Like you know okay this is the case [the procurement surgical procedure] we get the case done and then it’s finished” (P34). As noted by one participant theatre nurses were very good at focusing on the job at hand: “I think theatre nurses have actually got quite a unique ability to compartmentalise what’s going on and get on with the job with anything that they do” (P4).

Several participants reported the need to not dwell on their emotional reactions by hiding these behind the mask. Participants tried to shift their focus on the surgical procedure by suppressing from their minds any personal or emotional thoughts. For some this was very difficult as they had to not let their emotions take control during the surgical procedure: “It’s not like any other surgery and I’ve been exposed to a lot” (P14). Other participants, in finding a way to cope, made attempts to normalise the surgical procedure as this was the view portrayed by many perioperative nurses: “I was told to just treat it as any other case you would be scouting for” (P13). The following participant provided the following thought process which illustrates the view of pushing through:

You’ve got a job to do, you’ve got to be organised, you’ve got to establish a routine in your own mind about how you are going to do things, they call it initiative, they call it motivation basically its simply doing a job that needs to be done. (P17)

Several participants explained that they used their professional roles as a distraction to escape from the often traumatic or distressing aspects of their work. Other participants provided similar examples of focusing on the task at hand and only concentrating on their role in the procedure: “I like to throw myself into the deep end” (P33); “I just sort of got on with it [the procurement procedure]” (P5). Whilst other participants made attempts to focus on the surgical procedure till it was completed before they could address any issues they may have experienced. Therefore throughout the procurement surgical procedure these participants used their work as a means to focus on till they reached the end of the surgical procedure so as they could escape the experience: “I just want this to be over and done with [the procurement procedure] so I can get home ... and deal with my personal issues” (P21).

There was a perceived expectation that by *focusing on the surgical procedure* participants would be in control and be prepared for all contingencies that may occur during such a busy and intense procedure. One participant described the importance of focusing on the task at

hand and controlling any emotions in order to manage any problems they may be confronted with during the procedure:

So, that's like preparing for the patient, setting your theatre up, getting your instruments ready. Communicating with your surgeon, what it is that they might be doing, is there anything that they're worried about. There could be a change in tack [approach to the procedure] that I might need something else [another surgical instrument]. I know that we provide a lot of basic stuff here *[Name of Hospital] when it comes to the instrumentation, although the procurement team[s], do bring a lot ... of instruments up. (P25)

Participants were also forced to focus on the procedure and suppress their emotions as there was an expectation of urgency in the surgical team to procure the organs in a timely fashion:

The team just sort of came in [to the theatre] ... they gave us their preferences of what instruments they prefer if there was any special instruments [which they required] occasionally and we just got on with it really. It was just a question of getting on with it really, the overriding feeling. In some ways you were just told to get on with it. (P10)

During these periods participants did not have time to think of anything but to meet the demands of the surgical procedure and the needs of the surgical team. Another participant provided an explanation of this experience:

I didn't have time to think about things until you are there, when you are in the circulating role, you don't really have time to think too much about the patient because you are involved in more of a technical role as in your helping with the whole process [the surgical procedure]. (P15)

Within the literature other nurses also spoke of focusing on their work roles to dissociate from their emotions. In the critical care study investigating grief by Shorter and Stayt (2010) one participant in their study stated: "It sounds a weird thing to do, but I have a work mode, if you like that I employ, and I can turn that on and off. I think you develop this professional mode of being" (p. 164). According to Redinbaugh, Sullivan, Block & Gadmer et al. (2003) doctors who had experienced a recent death also reported "turning to work or other activities to take your mind off it" (p. 4).

5.4.1.2 Being accountable for their practice

Participants engaged in the second component of *getting the job done* which was labelled *being accountable for their practice*. This was a strategy used by participants to distract themselves from the graphic nature of the procurement process and the emotional impact of their work on themselves. Several nurses spoke of *finding meaning* through providing a high standard of care and placing emphasis on their contributions towards the successful outcomes of these surgical procedures: "We participated in the process, we were always professional about it and there was a job to do and we got on and did it" (P8). Another

participant also articulated a similar view: “Focusing on the importance of the role that we do” (P11).

Participants moved through the procurement surgical procedure completing their various role responsibilities and accountability to ensure that all standards of practice, policies and procedures were maintained and executed. One participant explained that she had learnt to view her role like any other major surgery: “It’s [procurement surgery] just like being in a major case really you know you think through what you need and what eventuates as you go along and that you have a duty of care” (P8). This was reinforced by another participant as indicated by the following response:

Perceived as policies and procedures ... [it] does help to maintain these. It keeps it [the surgical procedure] a little bit normal because it doesn’t, I mean in the end it doesn’t matter what you do, it’s still a patient, you still have to do the same things no matter what. It’s no different to cleaning up a patient before the patient goes to recovery and then back to the ward compared to cleaning up a patient [an organ donor] who may go to the morgue. You are still looking after that patient [the donor], that patient is still in your care. (P34)

Several participants in their attempts to normalise the procurement procedure explained that they had a professional obligation to provide safe, competent and ethical care for the donors within their care: “Professionally it’s still just maintaining your standards and doing the job that I do” (P7). This care, like all perioperative nursing care entailed the holistic care of the donor patients, prior, during and after their procurement surgical operation. However, many participants had to change their frame of mind about their work roles when making attempts at *pushing through* the procedure. One participant described this as: “I think it was just a case of, I can look at it just like as being any other surgical procedure ... you’re sort of doing your normal job really, scouting and getting what’s needed” (P28); “It’s just routine what you do basically for procurement surgery” (P27). Another participant provided another perspective:

It’s almost like your role is changing in that you are still there to carry out the patient care obviously but you are there more to procure the organs. I feel it’s more like okay we are doing this now and this is almost about the next step. (P15)

Although participants articulated their participation in procurement surgery as an emotional and traumatic procedure they held themselves accountable for their own practice roles. Several participants voiced wanting to ensure that the procurement surgical procedure was successfully undertaken, with viable organs to benefit recipients although experiencing emotional reactions: “For me, it was always an emotional sort of thing ... I suppose to some extent it was more being clinically focused” (P20). In *being accountable for their practice* participants ensured that they provided the highest standards of care and service to their teams. This ensured that procedure went as smoothly as possible as evidenced by the following participant response: “It’s such an important thing [the procurement surgical procedure] ... I mean the thing is if those organs are going off to

someone [the recipient] who needs the organs you still have to maintain your standards” (P7).

Normalising the procedure also assisted the participants to feel secure in their perioperative roles and be totally absorbed with their work, for example, counting surgical instruments and packs: “You did ... tend to, as you would normally ... take care of your instruments and take care of your packs and all that sort of thing” (P20). This practice however varied from one institution to another and often caused some confusion for surgical teams:

The whole other thing I found kind of tricky to get my head around was the counting of instruments. You know, you don’t count the packs [surgical sponges], but you count the instruments because you don’t want them to get lost in there [the donors body] you don’t want to lose any surgical instruments because of the cost [of replacing them] ... so that was a really strange [practice] you know for me. (P5)

Maintaining the same standards as any other surgical procedure was important to participants. While they were aware that they were operating on a cadaver donor where no harm could come to them should they have lost any swabs or instruments this process assisted the nurses to normalise the procurement process:

We always did a full count [for procurement procedures] and you know, you had a duty of care not to leave anything in the body. ... even though this person had been declared fit for retrieval we still followed the full count process and ensured that there was nothing left in the body that shouldn’t be. (P8)

Another participant provided this insight speaking of the process of counting surgical instruments as a charade used by nurses to normalise the procurement surgical procedure:

It’s [the procurement procedure] been treated like a normal surgery like we were doing a count and *[Name of Nurse] asked a very pertinent question yesterday and she said “Why did they ... are they doing a count”... the pretence is that we’re making it like a normal surgery. I said that’s like mainly for the psychological impact of the team. Certainly the first thing I’ve said to the night staff is ... “Why are you counting on the way out? You don’t have to, it doesn’t matter if anything’s [surgical instruments are] left in [the body], it’s not life threatening. So on that level *[Name of Nurse] mentioned it’s a waste of time and well it is but it’s the routine, a charade ... and why do we do that charade then, I goes “cause nobody really wants to face the fact that, that’s a cadaver on the table”... I do think that’s true, and I think that is why we do it and that’s international, same in the UK, same here [in Australia], same in America. (P23)

Other participants described immersing themselves in other work related activities in attempts at *pushing through* the surgical procedure to its completion. They believed this assisted them to feel comfortable in *finding meaning* through their work roles. They felt

they were positively contributing to the donor when they were able to provide the best care they could in line with their professional role responsibilities. Most participants made a concerted effort to check donors' details and their paperwork themselves. Although this is standard practice for all perioperative patients who come to theatre, often due to the hasty procurement procedures most coordinators and external procurement teams often pressured the nurses to get on with the commencement of procedures. One participant spoke of a situation where she wanted to check in the donor patient into the operating room to ensure she was being accountable for her own practice:

So, I just think it's important to do your job properly ... I'm a bit funny sometimes I like to, when a patient comes in [to theatre], I know they're brain dead, I know all that, but I still go through the process of checking the patient. I've done it my whole working life. I go out have a look at the patient, check the notes, check everything, all the paperwork even though I was told by the [organ donor] co-ordinator "Oh, you don't have to worry, I've done it all" and I said "you've done it all, but I'm the scrub nurse, I'll do my own check please." She got a bit insulted that I, that I had to do my own check and she said "You don't think I'd let the patient come around this far without making sure all the paperwork is there." and I said "I'm sure you did, but I want to make sure it's right for me too". (P29)

5.4.1.3 Advocating for the donor

Advocating for the donor was identified as the third component of *getting the job done*. During this time participants focused on *advocating for the donor* to make sure they were cared for properly throughout all of the stages of the procurement procedure. While it is common practice for perioperative nurses to advocate for the patient while they are unconscious during their surgery, within the context of this study they felt they should advocate for the cadaver donor. Several participants believed that they had an ethical obligation to their donor patients by: "being a patient advocate" or "protecting the donor from harm" (P24; P8; P32; P19). As an advocate, participants undertook specific actions such as assuring quality of care, defending the patient's rights and their dignity. Nurses viewed donor patients as being vulnerable and powerless and as such they needed to provide individual care and advocate for their body and their remains following the procurement process. Furthermore, they voiced the importance of always treating the donor as a person with dignity, compassion and respect.

During organ procurement procedures the advocacy role was heightened as the external procurement surgical team members had limited contact with the donor compared to the perioperative nurses and the organ donor coordinator who provided care throughout all stages of the procedure: "We are there from the beginning, till the end [of the procedure], everyone leaves once they procure their individual organs, we are the last ones there. We are essentially responsible for the donor until we transfer them to the morgue" (P22). Advocating for donor patients was a strategy used by participants to reassure themselves that they were doing something positive for the donor to overcome the often harsh graphic experiences of the procedure: "I think it's something that is quite special in that way, in that

it's not the same as normal patient advocacy that you would normally be involved in" (P15). Those participants that were able to advocate for the donor were able to see that the donors' wishes were honoured and experienced satisfaction and found a sense of meaning from their experiences.

By *advocating for the donor*, participants also protected the donor by ensuring that the surgery was undertaken with the team showing due respect for the donor and their body: "It isn't like treating them [the donors' body] like a piece of meat or something like that" (P7). Similarly, several participants reported speaking up as a patient advocate for example when a donor's incision was not closed appropriately following the procurement procedure. Several participants felt strongly that the patient should be afforded the same level of care as any other patient even though they were deceased; as they had just contributed to saving numerous lives. One participant described this experience: "I make sure that I am a patient advocate [for the donor]. I feel sometimes that if the patient, if in the end whoever stitches up the patient if they don't do a proper job that's very wrong" (P35). Another participant provided a similar experience where she advocated for the donors incision site to be sutured correctly:

I asked [the procurement team] ... and they said no ... I insisted very forcefully and he [the surgeon] realised oh I'd better do it because I said, "If you don't do it I'll get your boss in to do it". They realised that I meant what I said. (P29)

These situations were difficult as participants questioned the value of organ donation if the donors' body was not treated with dignity and respect. Being an advocate for the donor led to some levels of moral conflict amongst the team members however perioperative nurses were adamant that the donor's needs should come first. The same participant further elaborated her views in regards to this aspect:

Well, I just found it a bit insulting ... the patient had already given so much [by being an organ donor] ... the [donor] patient, the family had given consent for the organs and they should at least respect it and do the right thing by them and ... close the patient [the incision site] correctly. The [donor] coordinator, she got a little bit upset with me ... but occasionally you have to stand your ground. (P29)

Other participants explained that their advocacy role continued when providing post mortem care after the procurement surgical procedure. While they found it difficult to accept the death of the donor they made attempts at *finding meaning* from their death by advocating for a high standard of care which was holistic and spiritual:

I think I'm assertive enough to get my point across to basically tend to the patients needs. I say maybe one time out of ten I'll get some friction [from staff] but nine times out of ten people [the nurses] ... they just click out of whatever they are doing [and say], "Yes, that's a great idea, let's do that and stop for two seconds and do this [for example] give them [the donor] a warm blanket or change the dressing". (P33)

Advocating for the donor also caused some problems and conflicts amongst nursing team members. Some nurses were not able to cope with their participation in the procurement procedure and also found it difficult to provide post mortem care to the donor. These nurses would make attempts to avoid the donor and any care activities involved with the donor's body following the procurement procedure. One participant provided the following account of a fellow nursing colleague who avoided providing post mortem care activities towards the donor which frustrated other nursing colleagues: "Yes I was frustrated, she wasn't helping at all, if anything she was avoiding it" (P33). The participant further explained how the other nurses and himself confronted the team member:

I tried to encourage her to come over and help [with the donor], my colleague who was the anaesthetic nurse, although she was also tending to the patient and had similar views as I had, she became a little bit sarcastic in trying to get her point across to the other nurse who wasn't willing to help so much. I mean that didn't come across very well until I actually said to her in ... without any sarcasm or anything like that "Look can you come over here and give us a hand please?" And only then she eventually came over and assisted but it was a little bit, a little bit disheartening. (P33)

Participants also found it was difficult to advocate for the donor when other professionals had set attitudes such as focusing their attention towards recipient patients:

As I say the primary concern and focus was the recipient, so once the donor had donated people seemed to be well okay that person has passed away let's just tidy them up and drop them off [at the morgue] and it was sort of matter of fact manner or attitude. (P17)

As a result, participants felt it important to advocate for the donor by ensuring they were appropriately cared for during and after a procurement surgical procedure. They ensured that donors were presentable after a procedure should their families wish to view them prior to being transferred to the morgue. One participant emphasised this aspect by the following statement:

You have a duty of care to what you do, you are really focused on that and at the end of it you are then focused on ensuring that the family still have a person to which they can associate or identify with at the end of it. (P8)

Advocating for patients has been studied extensively within the literature (Breeding & Turner 2002; Hellwig, Yam & DigGiulio, 2003; Kubsch et al., 2004). Bull and Fitzgerald (2004) emphasised that advocacy was more likely to occur if a nurse was assertive. According to Schroeter (2000) several perioperative nurses found it difficult to confront team members on advocacy issues as a result of the theatre environment and working with surgeons and the surgical team members for long periods of time. As Schroeter (2000) emphasised: "conflicting loyalties pose a problem for perioperative nurses when they are exposed to the ethics of advocacy" (p. 1215). Similarly, the study by Boyle (2005) investigating the lived experiences of 163 perioperative nurses from the USA on advocating within the perioperative nursing setting also emphasised the need for protection of patients:

We are the guardian angels of these patients while they are asleep. The reason I say that is because we watch out for their safety because when they are asleep they can't protect themselves. They can't defend themselves from things that are going on. (p. 258)

5.4.2 *Suppressing hidden thoughts and feelings*

The second aspect of *getting the job done* was identified as *suppressing hidden thoughts and feelings*. Participants used this coping strategy to get through their experiences of procurement surgery in order to find *meaning* in what they were doing. This suppression meant that they did not get emotional or have wandering thoughts as they consciously pushed them from their minds especially during the busy and demanding procedure:

So it's very full on [the procurement procedure] and as I said initially you really don't have any time to sort of get an emotional hiccup sort of thing or sort of stop and think oh what am I doing type of thing [when participating]. (P8)

Participants spoke of suppressing *hidden thoughts and feelings* in an attempt to gain control whilst performing their work roles. One participant validated this aspect: "I try not ... to let it ... my emotions hinder my role in theatre ... we deal with a lot of trauma so I try not to let that upset my work" (P4). Another nurse gave a similar account: "You have got to get in and do it, do your job put your emotions to the back you can't ... let them [emotions] get in" (P19); "It's a job ... and that's what you have to focus on and I think most theatre nurses with any level of experience have got past ... [long pause] bringing any emotion into it ... they just have to get on with the job" (P4). Other nurses explained that they were *suppressing hidden thoughts and feelings* as a result of having to concentrate on their busy work roles, which demanded their full attention: "The focus is on the operation itself but in reality it's like ... you can't think of it or else you'd be cutting your limb" (P35). Blocking out other thoughts and emotions was therefore vitally important for the participants as it enabled them to concentrate and push through with the procedure:

There are times when you have to concentrate on what's going on [during the procedure] ... concentration is really necessary ... in order for you to get through ... any [surgical] procedure. You've got to sort of try and concentrate and block other things out of your brain. (P20)

Several participants found the strategy of *suppressing hidden thoughts and feelings* as helpful as it assisted them to move forward when they felt vulnerable or stressed by their work situations in procurement surgery. By keeping their emotions and thoughts suppressed, participants could keep themselves on an even keel. One participant referred to the strategy of not getting too emotionally involved as it was a necessary action to protect against getting burnt out from the job:

I think if you get too emotionally involved you can get burnt out way too much and if you think too harshly on things or get too involved with things

it's not good. I think as long as you can get in it and do your job really well ...
I think that's the best way to go. (P34)

Another participant provided a similar sentiment of keeping her emotions in check: "I'm probably sounding like such a cold hearted person here with no emotion [laugh]. But I don't let it affect me, I don't! I just see it as something that we have to do to get through the procedure"(P4). Moreover, several participants emphasised the pressures and expectations on perioperative nurses to undertake their roles in a professional manner without breaking down and being emotional during these surgical procedure. These expectations were quickly passed down to new nurses when they began to work in the operating room and were heavily embedded in the culture of the workplace. *Suppressing hidden thoughts and feelings* therefore was a necessary coping strategy to use if they were to be seen as credible to undertake the procedure:

You do have to show them [procurement teams] that you are coping because I suppose in some respect ... you have to show that you can do your job without sort of breaking down and then having them to support you because it's not the time and place to do that. (P20)

Participants did this as they did not want to be viewed as ineffectual to the success of the procurement procedure or be perceived as the weak link of the team: "You would be viewed as the weak link" (P20). Another participant suggested that suppressing emotions or thoughts was vital to the perioperative nurses' role and reflected the nurse's ability to cope with all sorts of trauma, crisis events and in managing confrontations with other surgical team members: "You can have a surgeon screaming at you and you've just got to keep focused and get on and ignore it and keep from being emotional" (P19).

However, some participants found it difficult to contain and suppress their hidden thoughts and feelings during the surgical procedure when they were dealing with young donors or could relate to a particular donor patient. One participant reflected that she could relate to the donor who was her daughter's age and could not stop herself from thinking about the donor throughout the procedure:

I was focusing on the task but also thinking oh this could be my children [on the operating room table having a procurement procedure] too at the time because they were the same age as my daughter ... I knew we couldn't save this child [donor], so his organs were going to go to someone who could benefit from them. So that's what I kept focusing on. (P27)

In an attempt to overcome these experiences, participants had to change their thinking by focusing on the benefits of organs being procured towards extending the life of recipients who were in need of these organs. It was through this thought process that participants could come to terms with *finding meaning* from the donor's death. For other participants suppressing emotions and thoughts continued throughout the duration of the long procurement surgical procedure which often extended beyond 5 hours. However at the completion of the procedure when they were alone with the donor, several participants

reflected this period as particularly difficult as emotions would surface: “As soon as the [procurement] team’s finished and everyone is leaving you are left with the [donor] patient then it’s very hard to ... stay focused and not get emotional” (P29). The same participant explained that she overcame this experience by: “You’ve got to detach yourself emotionally from the job and just do the job clinically and just function and do the job so that you can get through the experience” (P29). Similarly another participant spoke of this period after the procurement surgical procedure as a time when they began to think about the experience they had just participated in:

Relieved I think. Once the teams start to move out and then it all quietens down it becomes more respectful and people have more time I guess to think about what they’ve been doing and to think about the [donor] patient and to think about what they are doing. I’m relieved when it’s over ... that it’s done. (P30)

Within the literature other studies such as emergency personnel also have been reported to suppress their emotional reactions or thoughts as part of their work roles (Booth, 1998; Holgate & Di Pietro, 2007; Halpern et al., 2009; Regehr, 2001). Consistent with the current study, other studies also reported nurses remaining strong by suppressing their emotions at the death of a patient (Brunelli, 2005; Milligan, 2004; Onstott, 1998; Gerow, Conejo, Alonzo, Davis et al., 2010). In particular, the study by Onstott (1998) reported that operating room nurses (OR) stayed focused by compartmentalising which was emphasised as “remaining calm” (p. 128) in order to deal with a death occurring in the operating room and the grief associated with this after a surgical procedure.

In summary, *pushing through* was conceptualised as the first stage of the basic social psychological process of *finding meaning*. *Pushing through* had two distinct aspects which were described as *getting the job done* and *suppressing hidden thoughts and feelings*. During the first stage participants’ engaged in strategies to assist them to manage and suppress their experiences and behaviours when participating in procurement surgery. Some of these strategies entailed placing an emphasis and focus on their professional roles. In addition, participants suppressed their thoughts and feelings in an attempt at *pushing through* the procurement surgical procedure. As participants moved into the second stage of the basic social psychological process of *finding meaning*, which was titled *preserving self*, their need to protect themselves became a primary focus.

5.5 Stage 2: Preserving self

The second stage of the basic social psychological process of *finding meaning* was conceptualised as *preserving self*. In an attempt to overcome the basic social psychological problem of *hiding behind a mask*, participants implemented strategies to protect themselves from both the traumatic experiences of procurement surgery and the tragic circumstances of the donors they came in contact with. *Preserving self* was articulated by many of the participants as engaging in activities to maintain their level of well-being. In an attempt to manage their experiences participants purposefully began to strengthen their existing coping mechanisms and sought respite away from the stressful work environment.

This included engaging in self care activities and seeking support from family and colleagues. By *preserving self*, participants were able to work through their problems and individual needs and move forward in the process of *finding meaning* from their participation in procurement surgery. Three aspects of *preserving self* were identified: 1) *being resilient*, 2) *nurse self care* and 3) *seeking personal support* (See Figure 5.4).

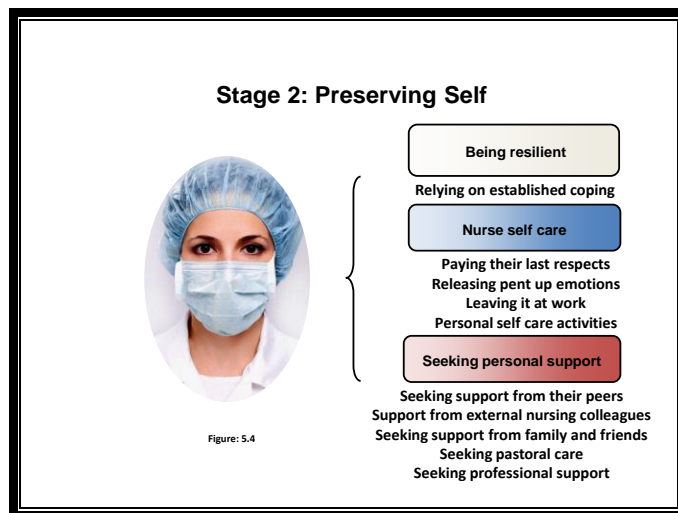


Figure 5.4: The aspects and components of preserving self

5.5.1 *Being resilient*

Being resilient was the first aspect of participants' *preserving self*. During this stage participants looked inside themselves to find resources from within to help them in times of stress when participating in procurement surgical procedures. Several participants reflected that dealing with procedures such as trauma and procurement surgery is inevitable and the need to be resilient is an expectation of the perioperative nursing role: "Pretty much that's what you were told that's the job, that's what you sign up for [when you're employed as a perioperative nurse]" (P10). The ability to be resilient was described as an important and vital attribute in maintaining their professional roles in procurement surgery. *Being resilient* enabled participants to make choices about how they were going to adapt to the changing work environment and alleviate the impact of the distressing aspects of their work. The perioperative nurse's ability to be resilient was influenced by their personality, character and previous life experiences.

Being resilient was described by participants as being able to cope with whatever comes through the operating room doors without having an effect on the nurse personally. Several participants reflected that perioperative nurses are a certain breed, having a hardy or resilient personality:

I think we're a special breed [perioperative nurses] ... I think you build resilience, it's inherent I think you are a type of person that can deal with anything that comes through the door and if it affects you then you're not to work in this environment, if you cannot handle limbs off, death on the

table then don't do it. So I think we are a type of person who is able to handle that. (P4)

Some participants articulated that their training or conditioning as a perioperative nurse shaped their resilience and adaptability within the perioperative nursing environment: "I keep fairly calm anyway, I don't sort of get rattled you know easily or anything like that" (P28). Other participants spoke of resilience and being adaptable as a process of becoming hardy as a perioperative nurse: "I have toughened up a bit ... You have too, definitely you can't be a little wimp sitting in the corner kind of thing" (P21). Similarly, this sentiment was expressed by another participant who felt that *being resilient* was perceived as being strong in character and unemotional or unfeeling: "So you become immune, the work toughens you up makes you appear unfeeling or uncaring about other people's circumstances" (P17).

For some nurses *being resilient* was forced upon them as an expectation of the role: "I'm actually quite a strong person in that regard and because ... I was of the era that you just have to get on with it, I just get on with it" (P10). Other participants spoke of the need to be resilient and cope as a result of pressure from colleagues:

There is a little bit of that [pressure from colleagues to cope] I guess, you're told to harden up, that type of attitude. Attitudes, like well when you have been here as long as we [older nurses] have ... you'll get used to it, [having to cope]. They're hard arsed bitches [referring to tough more experienced nurses] that have been here for 30 years [nervous laugh] ... just occasionally you'll get that attitude of other nurses saying we've seen it all and it doesn't bother us ... it shouldn't bother you sort of thing. (P5)

There was a perception amongst the younger perioperative nurses that resilience was acquired through years of experience and experienced perioperative nurses were better able to cope with procurement surgery: "I think the older ones [nurses, they] ... they also know all about life and how to deal with people and society whereas the younger ones still have years ahead of them" (P21). However, what the researcher noted was that older nurses had just learnt better ways to become more adaptable and to conceal the impact of these surgical procedures which had a remarkable effect upon them. It was also noted that these more experienced nurses felt overwhelmed and questioned their abilities to cope with certain procurement procedures involving donors who were children:

It's hard, the child was 10 years old and I remember just thinking I didn't know how I was going to get through the day actually and the day was very sombre and I was very glad when the day ended. (P10)

Being resilient was not always easy to maintain and several participants spoke of resilience and their ability to cope changing from day to day and being dependent on their personal or work situations:

We don't know how people are feeling and what's going on outside of their lives, outside of hospital [their work], whether they feel that ... they are emotionally fit to be involved in that kind of procedure on the day. (P15)

As a result, participants often spoke of showing an outward persona of *being resilient*, being able to cope, even when this might not always be the case on a personal level. One participant explained that several of her colleagues assumed that she was coping well however this was not always the case:

I always remember a friend saying to me, she's a bit older than me, and she said "I've got to admire you ... when something happens ... you just deal with it. You get it off your chest and then you don't worry about it anymore, it's not like it's something that reoccurs over and over for you or something you've got to worry about it, we know you've forgotten about it" and I said "Oh yeah" [nervous laugh]. (P28)

Other research studies have reported that nurses who have support within and external to the workplace environment are better able to cope and this in turn enhances the nurses' ability to be resilient (Bloomberg & Sahlberg-Bloom, 2007; Gillespie, Chaboyer, Wallis & Grimbeek, 2007; Guay, Billette & Marchand, 2006). Gillespie, Chaboyer, Wallis and Grimbeek (2007) investigated resilience amongst 2860 Australian operating room nurses and identified five important variables of resilience: hope, self-efficacy, coping, control and competence (p. 435). Some of these variables were also noted as important aspects in the current study as resilience increased as a result of nurses participating in organ procurement learning to cope, control their work environment and being competent to undertake the required surgery.

5.5.1.1 Relying on established coping

Relying on established coping was identified as the first component of *being resilient*. Participants tried to adapt to the stressful conditions of procurement surgery by focusing on using their own personal tried and tested coping strategies. For several participants putting up a defensive barrier as a protection against the distressing aspects of their work was important in them *preserving self*: "As I say, just that defensive barrier they [nurses] put up, that we all put up, I'm sure in the variable experiences we find ourselves in, we try to protect ourselves" (P17). Other participants employed strategies such as blocking out distressing aspects of their work or using denial or avoidance to overcome their personal experiences. However, they often found this difficult to accomplish: "I find I can tend to crowd my mind of the negative side of it" (P4). It was important for perioperative nurses to cope and get through the procurement surgical procedure: "Coping with the [procurement] procedure was necessary" (P16); "I think we have got lots of staff here who have been here for a long time and who, particularly are real copers ... you'll get people who can cope with anything" (P2); "I guess as you become more experienced as a perioperative nurse you, you are involved more with these [procurement] procedures and you learn to cope" (P13); "My level of understanding and ability to cope is much better just by being more experienced" (P15). Another participant described becoming desensitised to certain procedures as a result of having extensive experience. The participant reported the following:

I think as you have years of experience ... I have 30 years ... you do a lot of things automatically, a lot of the basic things automatically and then you

just go into the zone and away you go ... you become sort of desensitized to it as such. (P34)

Other participants were able to modify and adapt their coping behaviours and thoughts throughout the procedure by normalising the procedure to that of any other surgical procedure and patient coming to the operating room: "I think you look at it another way like with your experience you're working it's another work, another patient, another surgical procedure ... within the production line. It's just, another type of surgery" (P35); "It's just like any other [surgical] procedure I guess, you do your best, you do the best for the [donor] patient whatever the outcome" (P13); "You would go about operating in the same way as you would on a patient who is going to survive the operation and go out to be better off hopefully" (P20). Another participant provided a similar account reflecting the following:

I tend to just sort of keep things as normal as I can ... go with the flow ... I have been doing it [a perioperative nurse] for so long ... for me it's just like any other operation as such. You just get hardened to it [participating in procurement surgery]. I can sort of really distance myself; I can sort of not think about it [the procedure] ... it's just like operating on any other person really. (P28)

Other participants referred to the importance of having prior experience as a perioperative nurse as a prerequisite in their ability to cope with these surgical procedures: "Things which helped me was ... just my experience, just all my experience I've had on the floor [in the operating room] ... the longer you are a nurse the better you are able to cope and to manage the situation" (P14). Increased exposure and experience was not only helpful but was used as a learning experience to increase coping abilities as a perioperative nurse:

It comes with experience ... like after 24 years [as a nurse], you actually think like a perioperative nurse in a lot of things that you do anywhere else. And I suppose our experienced staff members do that ... you deal with things that well if you're doing a trauma, your learning from it all the time and you go and you just cope because you've got to ... It might just be more exposure and experience to coping. (P2)

This was similarly reported by another participant who referred to consecutive exposures to procurement procedures:

I just think, its experience truly, I do I think it's an age thing you learn to deal with it. I think nurses are very good at [coping] ... It gets less traumatic the more often you do it [procurement procedures] as well. (P4)

The ability to manage stressful work situations and cope has also been reported within the literature. Bloomberg and Sahlberg-Bloom (2007) assert that with increased levels of professional experience nurses learn to develop coping strategies to manage their stressful experiences.

In the current study, participants used conscious and unconscious methods of coping. A conscious method of coping was described by the participants as immersing themselves in their work roles. For some participants they drew on their previous experiences in theatre to cope with the demands of procurement surgery:

It's my job, I have learnt this because I have been in theatre for so long because I have worked in a lot of areas where we've dealt with real life threatening emergencies and I've lost a lot of patients in theatre. I feel, it's my profession it's my job and there are good things and there are bad things and in the job [long pause] and every job has that. (P3)

Several participants reported using their professional work roles and duties as a means of coping. These participants focused attention away from the trauma they were witnessing and experiencing by focusing on work related activities. This allowed the nurses the time to not think too deeply about what was happening around them by blocking out what they were dealing with. One participant described that whilst focusing on the surgical procedure she also absorbed herself with other duties in an attempt to block things out: "The [theatre] scenario, it's extremely messy, ... it's eskies and water and slush and mess all over the place ... so you actually find you can focus on cleaning up if you really want to block out things" (P4).

Within the literature, emergency workers also reported being totally preoccupied with their work. This was validated by a participant in the study by Karlsson and Christianson (2003) who commented: "When we were at the scene we were totally occupied by our work" (p. 432).

In this current study, participants spoke further about placing their experiences into perspective by comparing the procurement surgical experience to other more traumatic or devastating situations they had been involved in: "For me I've seen a lot coming from and working in *[another country] I've seen so much ... because I have dealt with horrible stuff before and experienced so many deaths" (P14).

Avoidance and detachment from the donor was another coping mechanism used by several of the participants to alleviate any emotional attachment to the procedure and in particular the donor. Other unconscious mechanisms were used such as denial to preserve themselves from being affected. An example of this was denying their reactions to death and the effect of caring for the donor: "I guess because they are a dead person now, this is where it doesn't really affect me now that much ... they are dead" (P7). Several participants spoke of not getting emotionally involved with the donor patient and the procedure as a protection mechanism in order to stay focused on the job and remain professional:

I try not to get emotionally involved, because in order to do your job correctly [pause] efficiently and correctly you really have to stand back and protect yourself ... I sound hard or horrible but it's just truly being professional ... in order for me to do my job efficiently and effectively I cannot get emotionally involved and that doesn't mean to say that I don't

care. It doesn't mean that I don't feel things occasionally, but it's my job I chose to do this job. (P3)

Another nurse spoke of not getting too emotionally involved as a protection mechanism from getting burnt out professionally:

I think if you get too emotionally involved you can get burnt out way too much and if you think too harshly on things or get too involved with things [towards the procurement procedure]. I think as long as you can get in and do your job really well and that I think, that's the best way to go. (P34)

Participants spoke of not looking at the donor's face as a means to block out and dissociate visually from the donor. Several nurses found that by not making a connection with the donor's face that they had more of an ability to cope throughout and after the procurement procedure. One participant explained doing this in an attempt to dissociate from dealing with operating on young donors who were deceased:

Certainly when I've done them [assisted in procurement procedures], a couple of dozen retrievals and the coping mechanism was not to get involved. I actually stopped looking at the [donor's] faces ... I don't look at the face when they've brought the patient [into the theatre], and I [noticed] a lot of other nurses did that too. I noticed that a lot of people [nurses] kind of looked more when they wheeled the [donor] patient out of the theatre. That to me is not being disrespectful to the donor. I think once you look at their facial features then it imprints [in your mind] it becomes more [real], you remember them [the donor and the experience], it's more human. It wasn't as if it makes you less human about the procedure, but I do remember it was a 23 year old or a 17 year old and I didn't look at the face either to make it so human and real. (P23)

Within the literature the use of avoidance and distraction has been reported as a coping mechanism in other professional fields. Previous studies have also suggested that professionals in other emergency work roles also used strategies such as distancing, distraction or emotional detachment to get through their work roles, protect themselves from emotional and overwhelming work situations (Karlsson et al., 2003; Regehr et al., 2002). In a Canadian study on ambulance workers by Halpern et al. (2009) the use of distraction and avoidance was used in order for these personnel to manage their emotional feelings. One of their participants commented: "I think my response normally was just to push aside that thought as quickly as possible and move on" (p. 183).

Similar findings were corroborated in a study by Karlsson and Christianson (2003) on police officers. These authors noted that police officers learnt to detach themselves from traumatic events as a defence mechanism. Within other nursing specialty areas, nurses employed coping strategies such as distancing from patients or stressful situations (Bloomberg & Sahlberg-Bloom, 2007; Gillespie et al., 2007). According to the earlier study by Pelletier-Hibbert (1998) on intensive care nurses also reported the use of strategies such

as distancing and detachment when caring for potential organ donors in the intensive care unit.

5.5.2 Nurse self care

Nurse self care was the second aspect of participants' *preserving self as a result of* participating in procurement surgery and moving through the process of *finding meaning*. During this period, participants focused on looking after themselves by taking off their mask once they were in a safe and private area. Several participants reported the importance of taking time to reflect on their own needs such as acknowledging the impact of the procedure and the donor's circumstances upon them. During these moments and when safe to do so they released their pent up emotions. Other participants chose to manage their feelings and emotions by leaving them in the workplace and not taking work issues home to their family. In caring for themselves, several participants came to terms with their participation and the subsequent care of the donor by taking a moment to pay their last respects to the donors. Moreover, this was a period when the nurses also undertook self care activities to overcome their experiences and promote their level of well-being. Whilst other participants recognised the need to reach out and seek personal support from someone that they could trust. *Nurse self care* had four components: 1) *paying their last respects*; 2) *releasing pent up emotions*; 3) *leaving it at work*; 4) *personal self care activities*.

5.5.2.1 Paying their last respects

Paying their last respects was identified as the first component of *nurse self care*. This period was the opportunity for participants to make their peace with the donor. As previously discussed many participants found it difficult to witness and assist in what had been done to the donor's body leaving them feeling uncomfortable on many levels. Therefore, they had to make peace with themselves and the donor. *Paying their last respects* was a strategy used by many of the participants to connect with the donor on a spiritual level, to absolve themselves of any wrong doing, to thank them for their donation and the opportunity to be there at the advent of their death. Participants justified this by the following comments: "I'm just saying a thank you for me I think" (P15); "I think for me it was like the whole admiration thing for this person" (P22). The following participants provided another viewpoint of her experience:

I feel for me that it's quite ... I don't know if spiritual is the right word but I do feel quite sort of emotional and spiritual about it [having participated]. In that, at the end [of the procedure] I always like to sort of say a thank you to the donor in my own head ... in that the person [donor] has been able to help someone else or lots of people you know to sort of change their life. I'm just saying a thank you for me I think ... to the donor ... it's just in my head ... it's like a thanks you've done a good thing. (P15)

Moreover, another participant viewed this time with the donor as a time to reflect on the loss of the donor's life, their choice to donate and the benefit to recipient patients:

Well sometimes, I think to myself whilst cleaning them [the donor], I sort of thank them ... just quietly reflecting upon their [the donors] choice and the massive impact it has made in terms of you know the people that will benefit and ... with their loss of their life and the sort of impact that has made on their family and the loved ones [they have left behind]. I just sort of think, I'm a little bit grateful, a little bit sad but I try to give them [the donor] ..., make sure they look presentable, ... comb their hair wash their body properly of any residual prep things like that. I don't really say much of a prayer, I do hold their hand. (P33)

Participants reported that as a result of *paying their last respects* to the donor they were able to find meaning from their participation and in the process make peace with themselves and the donor. Therefore, honouring the donor and their contributions they had made by donating their organs was an important aspect of *finding meaning*. This was validated by another participant who explained that laying her hand on the donors shoulder and reassuring the donor albeit deceased was her way of dealing with the death of the donor:

Well actually, I do it with not just the organ procurement [donor patients] but I do it with any patient which has passed away on the table, and I didn't realise I did this until recently somebody actually stopped me and said "What are you doing?"... and what I do is, I actually put my hand on them [the donor] because again I'm almost always the scrub nurse, and once I've unscrubbed I actually go over to them [the donor] and I didn't realise I did this but I put my hand on them [motioning to the shoulder] and I don't actually say anything. I just kind of go "It's okay *[Name of donor]" and that's it and I have done this when I look back, I have done this to every single patient that has ultimately passed away. It was only when, I think it was a grad nurse said "What are you doing?" and I went "Oh, I guess I'm saying a prayer." I don't know what it is I just put my hand on them and go it's okay and that's it. Maybe that's my way of dealing with it [nervous laugh]. (P6)

Participants engaged secretly in the strategy of *paying their last respects* whilst *hiding behind a mask*. Being alone with the donor allowed them an opportunity to pay their last respects in private: "Well no one knows what you're doing because there's [pause] no other nurses are with you" (P23).

Paying their last respects entailed saying a secret thank you, saying a prayer or placing a flower on the donor without the other team members knowing. Several participants disclosed that they conducted a secret thank you to the donor: "I just look up at the sky [referring to heaven] and just say a wee thing such as a blessing" (P23); "I do say ... 'bless you *[Name of donor]' like for any patients that I lose" (P19). Another participant disclosed silently speaking to the donor in acknowledgement of their death: "I just stand near them [the donor] and acknowledge that they've gone [passed away] and [I] just sort of mentally, silently spoke to this person [the donor], the dead body as ... there's not much else I could do" (P26). Other participants also reported that they often talked to the dead donors whilst performing post mortem care activities such as informing them of the care they were about

to receive. For several participants this was also a form of *paying their last respects* when treating the donor with dignity, respect and as a whole person. However, this was reported to be conducted in a discrete manner:

No, I don't think they [the other nurses] knew or were aware ... I used to speak to the [deceased] patients [donor] ... all the time I'd say "I'll be washing your back now" or "I'll be [doing this]" or "I'm just going to brush your hair" [I was] just making out that they [the patients] were still alive, like they're still there. (P21)

This was also recounted by another participant who stated that she too spoke to the deceased donor patient however she made sure that what she was saying was not noticeable to the other team members:

I think, I kind of I didn't speak out loud but like I'd say "Oh, you'll be okay" [nervous laugh] or say something like "you'll be alright now" and "goodbye *[Name of the donor]" or something like ... "you'll be alright" ... because I do some weird things, like talking to patients who have died. (P32)

Paying their last respects to donors who were children was particularly difficult for a lot of the nurses. One participant recalled talking to a child donor, and saying endearments to the child whilst providing post mortem care which was extremely difficult for all the nurses involved:

We'll [the nurses'] we sort ... of said "You're with the angels now or something [to that affect] and we were sort of talking like that to him [the child donor], throughout [saying] there's no more pain now and things like that. (P28)

Talking to the deceased donor patient was also a finding reported in the earlier ICU study by Pelletier-Hibbert (1998) who noted that nurses working in the ICU spoke to the donor as a coping mechanism although they were aware the donor was deceased. One nurse in her study stated: "Talking to the donor, I think that might be a coping mechanism, because it's kind of hard to deal with-what I'm doing is just keeping a shell so that someone else can use it" (p. 234).

Within this current study, participants also used prayer as a way to pay their last respects to the donor. This too, was undertaken discreetly without the knowledge of their colleagues. Several participants validated this point by stating that they were discrete and it was not noticeable to their colleagues: "No I don't think so ... I didn't make it obvious" (P26); "I say a thank you to the donor ... it's just in my head (P15); "I do a silent thank you and prayer ... I didn't do it overtly (P22).

Saying a prayer assisted the study participants to make peace with the donor and overcome their experience. The nurse and donor relationship at the completion of the procedure was viewed as sacred; as time to acknowledge the donor: "I say a little prayer" (P19); "I just say a little prayer, my own little prayer ... you know 'you will be with God now, you'll be alright'

sort of thing, you know you've done the right thing" (P29). Another participant viewed prayer as a coping mechanism: "You say a few prayers [nervous laugh]. I mean that's a coping mechanism in this particular hospital *[Name of Hospital]. I say a few quiet little words here and there" (P30). Other participants used the time of *paying their last respects* as a moment to accept the situation and find meaning through the experience:

So, I've overcome that by praying even though the person, the procurement has finished and we are left with the body. I have overcome that by praying for that particular person and that can be like for days. It [the experience] stays with me for days ... and I just continue to pray for that person's spirit or soul to be taken to heaven. It's like an inter-session. (P25)

Several nurses viewed the time of providing post mortem care to the donor as a privilege, as they were usually the last people to advocate for them and prepare them for viewing by their family and for their journey to the morgue. Another participant described this interaction with the donor patient as a private affair: "I don't make a big thing of it [saying a secret thank you or prayer] you know [nervous laugh] or make a spectacle. It's a very private moment and most people are probably not aware of it" (P28).

When the researcher asked participants whether they witnessed any of their fellow colleagues doing the same, several participants responded that they were not aware of this. One nurse responded with the following comment: "I didn't notice anything, no I didn't notice anything unusual" (P22). However, as participants were *hiding behind a mask* they were not aware that other nurses also very discreetly did a secret thank you or prayer at the time of providing post mortem care as they often hid these private and personal events from their colleagues.

Conversely, some participants emphasised they partly came out from *hiding behind a mask* during these events when they revealed that some of their closer colleagues would be aware of what they were saying or doing to the donor. The following participant provided this account:

People that know me, know ... what I do and I mean they'll say to me "Oh, you'd better pray for this one [deceased patient]" or things like that, you know they sort of say it in jest but they know that I do it [say a prayer for deceased patients]. (P28)

Other participants disclosed that only close and trusted colleagues would have knowledge of them conducting a prayer over the donor: "Sometimes they do [other nurses witnessing the event]. They've asked me and I've explained it to them [explaining to colleagues what she is doing] and they seem okay with it" (P25). Another participant validated this aspect:

It would depend on who's in the [operating] room. If it was ... my friends, I know they wouldn't be offended by it [saying a prayer] ... I don't think anyone else [other nurses] would be offended in saying a prayer. I would say [to colleagues] well hang on a minute let's say a couple of prayers. (P30)

Some participants reported *paying their last respects* by placing a flower onto the donor's chest when completing post mortem care activities which was expressed as symbolic of saying thank you to the donor:

No, the only thing that I like to do if you can get them is [a flower] when you wrap them up we put a flower ... a flower of some sort [on the donor]. When we can, we will get a flower and just place it on top of them [the donor] ... and no I don't say a prayer but you sort of stand over them and you hold their hand and you pat their hand and you look at them and it's like saying thank you I suppose, for what they've done or what their family has done. (P20)

For another participant, anointing the donor with warm water assisted her in paying her last respects to the donor within her care: "I don't have oil with me but if we've got warm water I usually anoint the person on their forehead" (P25).

5.5.2.2 *Releasing pent up emotions*

Releasing pent up emotions was the second component of *nurse self care*. After *hiding behind a mask* and being expected to cope whilst in their work roles participants reached a point where they could focus on themselves by *releasing pent up emotions*. As a result of their participation, several participants had experienced a variety of emotions which they had bottled up throughout the procedure. The range of emotions expressed was reported as sadness: "My heart just sank for the donor" (P2); to anger: "I was angry at what I had to witness and what was happening to the donor" (P29). Participants got to a point where they were *releasing pent up emotions* in private away from their colleagues and their family an example of this was crying in private: "I have a cry and sort of release it [emotions] in private" (P19). Another participant explained that as soon as she was away from work and in her car driving home was the time she would be *releasing pent up emotions*. The participant provided the following account:

I had a cry after work while driving home ... I'm much better if I have a little cry or I get cross or I shout in the car. I get it out of my system in private and on my own ... That is obviously one of my coping mechanisms but it has to be private I don't do it in public or try not to. (P10)

Moreover, other participants spoke of experiencing emotions such as spontaneous laughter or giggles as a stress response. This was also noted by the researcher when participants recounted certain aspects of their experiences. It was acknowledged that a nervous laugh was expressed as a sign of having difficulty in processing their emotions or being highly stressed. Many of the participant's spoke of their experiences with a nervousness and laughter at certain situations they had experienced. One participant reported this form of laughter and humour as an emotional stress reaction during or after the procurement surgical procedure. This reaction was uncommon although it was reported by the following participant:

Unfortunately, I think it's like a stress reaction thing, not so much now as I've gotten older but I get the giggles. Which is rather unfortunate, I think it must be a stress related thing when something will happen ... I will be fine and yet it's probably rather unfortunate but it's not something that I can control really, something will just happen and that's it, it's probably hysteria more than anything. (P18)

The same participant further elaborated that there were certain situations that sparked this laughter. What was reiterated was, on these occasions, it was not about being disrespectful towards the donor but about overcoming the stressful situation:

When I've been laying people [the donor] out, well it's normally something they [other nurses] have done and the way I'm laughing is infectious so they're also laughing with me. It's not a disrespectful thing it's just something that's happened and a way of dealing with it I suppose. You have to try and see the funny side of it. I think you have a choice ... if you want to be sad, I mean it is a sad situation but you can't let it get you down. (P18)

In support of these findings, several authors such as Buxman (2008) and Chinery (2007) also reported the use of humour to have been used constructively as a buffer against stressful situations within the operating suite. The use of humour and expressions of laughter during stressful situations were also identified in other nursing specialty areas within the literature. A study from the UK by Hopkinson, Hallett and Luker (2005) identified that humour was used by their nurses as a distraction technique to escape certain difficult death situations. A participant in their study stated:

I think we've just got a very black sense of humour, because it's funny to us. It wouldn't be...if...we'd never discuss (the funny side of death) outside work because people wouldn't appreciate it...that in all this stress there was something you can... you can suddenly, just giggle.....I suppose it's one way of relieving stress. (p. 128)

The descriptive qualitative study of intensive care nurses by Badger (2005) also identified the use of humour as a coping strategy to externalise their stressful work situations and emotionally compartmentalising their feelings: "We laugh a lot and have a sick sense of humour, making jokes out of what are in reality dreadful situations" (p. 66). Similarly, Pelletier-Hibbert (1998) study also reported humour being used by nurses caring for organ donors in the neurologic intensive care unit. Looking in other areas such as emergency workers similar findings were also identified that supported the current study findings. A study on ambulance workers by Halpern et al. (2009) found the use of black humour as a coping method to manage emotional vulnerability and as a bonding technique used amongst the workers. This was also reported by one participant in the study by Halpern et al. (2009) who stated: "If you can't laugh, you'll cry. Because you, if you can't brush it off, you're going to internalize it and if you internalize it, you're not going to be able to do the job" (p. 184).

Within this current study, the timing and place of *releasing pent up emotions* was different for each participant. Some participants reported *releasing pent up emotions* at the completion of the procurement procedures. This occurred as a result of external procurement teams departing the operating room, being alone with the donor who now had taken on the physical appearance of a person who was deceased. For other participants this was a difficult and a solemn time in which to pay respects towards the donor. However, for some the time of providing post-mortem care was another opportunity to release their pent up emotions. During these periods there was usually no music played in the operating suite and there was an expectation that everyone talked quietly and respectfully. One participant was therefore surprised and angered when one of her colleagues expressed laughter in a joking manner. This made the participant quite angry and upset as she felt they were disrespectful towards the donor:

It's happened to me once with a colleague and they wanted to chatter and laugh and joke and I was actually trying to lay the person [donor] out and I got quite upset and quite cross about it because I found it quite disrespectful. (P10)

When questioned by the researcher on how she managed the situation, the participant responded:

I didn't confront them, I walked off and calmed down and came back because I could feel myself getting quite tearful. That's how I dealt with it, really I didn't want to confront her. Maybe that was the way she dealt with it by laughing and joking. I don't know, people handle it [the procurement experience] differently. (P10)

5.5.2.3 *Leaving it at work*

The third component of *nurse self care* was articulated as *leaving it at work*. Several participants articulated that leaving it at work was a strategy of divesting their experiences at the work place. This allowed them to create a distinct boundary between their professional and personal life. Several participants chose to switch off from their professional roles: "I've always been a person as soon as I walk out the door [at the end of work], I switch off" (P10). Similarly participants choose to leave their experiences at work so as not to burden their families with traumatic details about the procurement procedure: "I don't like to burden my family or any of my friends with my problems" (P10). Some nurses made a distinct divide of their professional and personal life's by leaving any work issues at work. These participants felt that their family should not be privy to certain details of their work situations:

I don't think it's any of their [my family's] business ... I discuss very little at home [about my work] you know we discuss my day ... but very little about what I do in detail. I don't think that they need to know the details of my work experiences, I mean they know what I do [being a perioperative nurse]. (P4)

Several participants spoke of the importance of talking to someone who had understanding of the procurement experience. These participants felt that they could not take their experiences home to discuss this with their family as they would not understand what they had been exposed to. Moreover, participants disclosed that if there was no support forthcoming from their work environment that they continued to be *hiding behind a mask* and suppress their trauma, as they had no one to turn too. Another nurse felt that she had to protect her family from the distressing aspects of her work as they would not understand aspects of her job. She also felt it was unfair to offload to her family by the following comment:

I don't like to burden my family or any of my friends with it [my experiences during work]. I don't like to take my work home to my family, it's very difficult when they're not doing this job to try and understand what it's like. They are not nurses, they don't come from a nursing background so it's very difficult and they [long pause] I find they would also find it quite distressing and I don't want to distress my family so I tend not to do it [seek support from family]. (P10)

Leaving it at work was also described by the theme "leaving work at work" by the earlier study of intensive care nurses caring for organ donors by Pelletier-Hibbert (1998). Similar to the current study these nurses felt that it was unwise to take their work home. Therefore they used the strategy of separating their work and professional lives (Pelletier-Hibbert, 1998, p. 233). The qualitative study by Badger (2005) also reported the nurse participants in his intensive care study did not take their work issues home to their family. One participant in this study stated: "I really don't talk about my job a lot when I get home because I feel like a lot of [what happens on the unit] is just a big downer for everybody else that's going to listen to me" (p. 67). Similarly, the study by Ekedahl and Wengstrom (2006) on nurses coping strategies in cancer nursing also mentioned that nurses trained themselves to put aside their work day: "It requires training to leave this job behind and to put it aside" (p. 133).

5.5.2.4 Personal self care activities

The fourth component of *nurse self care* was the need for participants to undertake *personal self care activities*. Nurses reported engaging in *personal self care activities* as a necessity to assist them in managing their experiences in the workplace. *Personal self care activities* provided an opportunity for participants to take some time out to rest, relax and rejuvenate away from their work environment and recover in private by focusing on their own well-being: "I'm really stressed afterwards ... I try to think about it [the experience] myself ... I don't actually talk about it to anyone. I don't want to talk about it ... so I will close off" (P35); "I shut down basically. I get very withdrawn for a week or two or a couple of days and then I'll start to pick up again" (P29). As a result of their experiences participants undertook *personal self care activities* such as getting enough sleep, drinking, exercising and taking time to process their emotions whilst also engaging in spiritual or religious practices. In addition, they spoke of doing some hobbies such as drawing and gardening to unwind from their day.

Several participants explained that they were often emotionally and physically tired after participating in a procurement surgical procedure. Being physically and mentally exhausted limited some participants' ability to cope and function properly. Therefore, these nurses opted to sleep to alleviate their stress and recover physically: "Usually I'm just really exhausted I'll just go home and sleep because we always do them [procurement procedures] during the night" (P21); "Sometimes, I'll go home I'm usually very tired and all I want to do is go to sleep" (P35). For another participant, the ability to sleep and recover gave her the strength to confront her experience after having such a rest: "At the time because it was late at night I just went home and slept on it, slept it off and dealt with it afterwards" (P27).

Participants also undertook self help activities which could in the long run be detrimental to their health and well-being such as drinking alcohol. Some participants reported drinking alcohol as helpful in numbing their experiences in attempts to unwind from their day or to erase or forget about their experiences for a short period of time. One participant reported drinking in an effort to forget or dissociate from their experiences as a coping mechanism: "My coping mechanism was I went home and had a very long stiff drink" (P26). Drinking was similarly reported by another participant:

We [a colleague] went out that night drinking, we were a bit flat and sort of went out and thought yeah we will go out and have some fun you know life's short and all that but it didn't help. I just went out and tried to have a few drinks that night and that didn't even work because we felt a little flat so we didn't really stay out. (P18)

Although drinking alcohol was used as a personal self care activity, participants found that drinking was not helpful in dealing with their problems in the long term. One participant qualified this when she reported that as a result of experiencing such stress related to procurement procedures she would continue to hide and suppress her emotions by the use of drinking alcohol in private: "I have a glass of wine and a few cigarettes [Laugh] ... I'm a closet drinker possibly" (P30); "I have a glass of wine" (P29). This was similarly reported by another participant who also stated drinking as a way to escape her work experiences:

I used to drink to forget about my experience ... I think it was safe to say when I was a younger [nurse] I used to drink [alcohol] to forget, but I noticed I was drinking more and more so I stopped because I thought I could quickly turn into an alcoholic [nervous laugh]. In all seriousness I felt that is what could happen to me so I made a conscious decision [not to drink anymore] and also alcohol didn't do it for me. (P10)

Other participants reported that although they too would drink as a way to escape from their days events they often could not drink as they were either on call or they had other duties or family commitments which required them to be sober: "By the end of the day, you want to crack a bottle of wine but ... I'm normally on call so I can't drink" (P19); "On school nights, I would try not to have a wine ... and save it for the weekend and alternatively speak to a friend" (P23).

The study by Regehr et al. (2002) on ambulance paramedics also described participants using alcohol as a short term coping strategy. One of the respondents in their study stated: "I just basically burned out and fell into a pot of booze. Then I quit because it was killing me, killing my family, killing my work" (p. 508).

Within the current study participants also reported engaging in helpful self care activities such as undertaking physical activities to relieve the tension and stress of the day and their experiences in procurement by focusing on increasing their feelings of overall well-being. These participants chose to exercise: "I have a swim" (P23). Similarly another participant explained that physical exercise was helpful in relieving some of her anguish:

I think physical, physical exercise is good I used to swim and you know and all that sort of thing [exercise] so I think ... that sort of doing a bit of physical exercise you know sort of gets rid of a little bit of that extra angst. (P34)

Whilst other participants chose to do things which were more self-fulfilling and positive such as gardening to relieve their stress and increase their well-being: "I do a bit of gardening" (P29); "I garden to relieve my stress" (P30). Similarly this was also validated by another participant:

I love gardening, I really like gardening to de-stress. I know I can't do it there and then, but you know when I do get some time off and things like that I love to just be at home in my garden. I've got quite a large [garden], I'm on a property on my own and I've got a lot of mowing to do and I've planted trees and things like that. (P25)

Having contact and time with pets was also used as a personal self care strategy as described by one participant: "After these [procurement] procedures when I'm stressed, I go home pick up the dog, and have a cuddle" (P35). Walking the dog was also reported as another physical activity which was used to relieve stress by being outside in nature: "I've got a dog so I walk my dog, I love the beach so I go to the beach" (P25); "Me personally I take the dog for a walk (P30); "I go for a stroll around the lake, I take the dog for a walk down around the lake" (P29).

Other participants chose to focus on some down time and distracted themselves with interest such as their hobbies to relieve tension. These activities were predominantly quiet activities used to escape or block out their thoughts of their experiences such as reading a book: "I think I've just learnt to try to put him [the donor] out of my mind completely like just de-stress read a book, get away from life" (P21). Whilst another participant spoke of drawing and sketching the donor as a way to externalise her experience:

Well I did, I sketched, I did a sketch of the impression of the body that was left, the laid carcass so that was sort of cathartic. Because I'm an artist of sorts so I did, I got it out by drawing. I found that very good at expressing or trying to externalise the image that was in my brain ... I didn't keep the sketch, no I don't remember what happened to it, it was probably fairly

hideous so I didn't want to keep it. It was more externalising some of the stuff that I'd [pause] had experienced. (P26)

Other general activities were reported as cooking or socialising with friends over a coffee: "I love cooking so I'll have a nice meal, glass of wine something like that. Go out for coffee with friends" (P25). Other participants chose to pamper themselves such as go out with friends shopping to relieve their stress: "But when I was like younger and stressed from work ... some girlfriends who were around my age, we went out sometimes like to go shopping and then dinner that sort of thing" (P35). Some nurses spoke of having a warm drink and shower to relax: "Oh I have a cuppa tea [laugh] yeah a nice warm cuppa tea ... and a nice hot shower [laugh]" (P28). Moreover, for other nurses dealing with their stress was overcome by using prayer and spiritual practices to nurture their soul such as meditation to relieve their stress and maintain their well-being: "I use meditation to relieve my stress" (P22); "I use prayer to help me after the experience" (P22); "I overcome the experience by praying" (P25).

5.5.3 Seeking personal support

Seeking personal support was the third aspect of participants' *preserving self as a result of* participating in procurement surgery and moving through the process of *finding meaning*. This period saw many participants acknowledge that they required support as they could no longer continue *hiding behind a mask* in order for them to *preserve self*. Participants reported that they did not usually seek support or were not always supported by their surgical colleagues and consequently chose to obtain external support. As reported by several participants *seeking personal support* often took time. One participant noted she had not spoken to anyone in her 20 year nursing career about her experiences in procurement surgery until speaking with the researcher for this study: "You're the first person [the researcher], I have never spoken about my feelings and experiences ... actually that was quite cathartic ... thank you" (P10). Similarly, this was also noted in the study by Holgate & Di Pietro (2007) on Australian volunteer firefighters when a female participant in their study found it helpful to talk about her experiences and the opportunity to "offload" during the interview process: "I've very much enjoyed being able to discuss all this [in interview] and have someone listen" (p. 36). Within this current study *seeking personal support* was an important process in participants *finding meaning* from their experiences. Five components of *seeking personal support* were identified: 1) *seeking support from their peers*, 2) *support from external nursing colleagues*, 3) *seeking support from family and friends*; 4) *seeking pastoral care* and 5) *seeking professionals support*.

5.5.3.1 Seeking support from their peers

The first component of *seeking personal support* was the need for participants to reach out and seek *support from their peers*. For some participants seeking support from their peers was the first step of coming out from *hiding behind a mask* and testing the waters by talking about their experiences in procurement surgery. Participants used the strategy to offload and validate their experiences and to talk in general about the procurement

procedure. During this time, they sought support from their closer peers who they knew they could talk to in confidence and who would understand their experiences. Some participants sought support from their peers as a coping strategy “Very often all we need is a chat with our colleagues and that’s the way we deal with it” (P4); “I think they [perioperative nurses] probably sought the opportunity to sit down and discuss the various aspects of it, which concerned them with people [colleagues] who understood” (P8); “[We] sort of hung back and had coffee and talked it was nothing formal” (P5).

Other participants reported *seeking support from their peers* who were more senior nurses as there was a perception, that they had extensive work and life experiences and that they would be better able to provide more genuine support and understanding: “No, the older ones [nurses] that I have worked with some of them [and they] have all been very open and wanted to talk about their experiences” (P20); “Well, I had this senior nurse in *[Name of Hospital] ... she was wonderful to talk to” (P6). In addition, it was important for participants to seek support from select peers who they could trust: “You have your friends at work that you can talk to ... you sort of build friendships here *[Name of Hospital]; you might talk to people but not formally just informally” (P5). Seeking support through friends at work was validated by another participant: “I have some good friends on the floor who are nurses in the operating theatre who I could talk to” (P12). However, one participant explained that if her trusted work peers were not available [referring if they were on annual leave] then she would not seek support from other peers: “If I’m lucky and the regulars [nurses] are on *[Names of Nurses] then it’s very easy I can talk about things and if you’re unlucky and my friends are not at work [on leave] I’m withdrawn for a couple of weeks” (P29). Other participants spoke freely with the researcher about making sure they chose the right peers for support. This was due to trust issues amongst the perioperative nurses:

I don’t really talk to the scrub, or scout [nurse] who were there [participating in the procurement surgical procedure] but I do talk to a friend who was ... an anaesthetic nurse who I trusted ... I just felt more comfortable talking to her. (P32)

Peer support was often sought from nurses who had not participated in the same procurement procedure. This was reported as a conscious decision by participants as they felt more comfortable seeking support from peers who were not directly involved in the procurement surgical procedure experience so as they could not pass judgments on the experiences discussed:

Sometimes it gets a bit much but I, I try and select friends that I want to be with and talk about it, I don’t, I try not to be with people that I don’t particularly like or I’m a bit selective in that way. I wouldn’t talk to those people ... and not necessarily the people that were there [in the theatre at the time of the procedure]. (P24)

When participants talked to the colleagues who were present at the time of undertaking the procurement procedure they disclosed that these conversations were superficial and clinically focused on how the procurement surgical procedure was undertaken: “After the

procedure there was chitter chatter with the other people there, the nurses and the orderlies were there too doing their duties ... they were all talking about the [donor] person basically” (P22). These conversations were viewed as small steps in testing the water amongst their peers in attempts to validate their own experiences and thoughts in moving towards the process of *finding meaning*. One participant disclosed: “Of course you are thinking the same thing but you may not be saying it ... sometimes you have to wait for others to start talking about it” (P27). Therefore, it was noted that when *seeking support from their peers*, participants did not discuss the personal impact of these procedures with their peers but just talking helped them cope:

I guess you talk about it [participating in the procedure] amongst yourselves at the end [of the procedure]. The nurses talked about it [the procurement procedure], just like everything, how did that happen [the donors’ death], what happened, what was the trauma [injuries of the donor], why couldn’t they [the donor] be saved, just like you would normally discuss anyone [else] that comes in for any other operation. So I guess by talking about it in general is a coping mechanism. (P30)

This was also noted by another participant who disclosed speaking to her peers with the discussion focused predominantly on their reactions on the clinical aspects of their experiences:

Most of the time we discuss how we felt at seeing and observing the changes actually in the person’s [the donor] body as the last organs were being harvested and everything was closed [sutured] up and the monitoring was closed down and turned off. (P11)

Other studies corroborated the current study findings that nurses often just needed to talk to their peers about their experiences. A survey study by Dixon, Vodde, Freeman, Higdon and Mathieson (2005) also reported that nurses sought support from their peers as a coping strategy when faced with the loss of paediatric and adolescent patients. In the Australian study by Holgate and Di Pietro (2007) on volunteer fire fighters experiences of readjustment participants reported peer support as more effective than counselling. One participant in their study felt that more senior peers were better able to support them: “Counselling is not the most effective way [to debrief] more effective would be to utilize the older blokes who have the experience as peer support” (p. 36). A similar finding was also identified in the study by Redinbaugh, Sullivan, Block and Gadmer et al. (2003) which investigated doctor’s emotional reactions to death of a patient. This study also confirmed that 84% of resident and 89% of interns relied on talking with each other about their experiences when encountering a death (Redinbaugh et al., 2003). This was also reported to occur amongst hospice workers as reported in the study by Ablett and Jones (2007) when a participant emphasised: “I talk to colleagues and we do actually discuss how we feel or how something could have been managed and we give support that way” (p. 737).

5.5.3.2 *Support from external nursing colleagues*

The second component of *seeking personal support* was the need for participants to reach out, and seek *support from external nursing colleagues* who worked in other areas external to the operating room environment: “I have got a couple of close friends from work that I keep in contact with too ... from other specialties who I can talk to for support” (P33). For some participants talking to external nursing colleagues was beneficial as it allowed the nurses to talk openly about the procurement surgical procedure. Another participant spoke of *seeking personal support* from friends who were also nurses:

I have a couple of friends who are nurses because not a lot of people actually quite understand. I actually rang a girlfriend of mine and had a good old cry on her shoulder and said it was just a horrible procedure etc. (P19)

As these support colleagues had limited knowledge about the theatre environment and work in procurement surgery, participants were able to share as much or as little information as they felt comfortable. This was helpful to these participants as they were *preserving self* by slowly having an opportunity to come out from *hiding behind a mask*. Participants reported seeking support from nursing colleagues in the acute care area of the emergency department:

If I need to talk to someone, I tend to find I have got a few contacts in the emergency department. They are actually quite responsive for talking about these sorts of things, they don't really understand what's going on in the theatre but [they are] just someone to de-brief with, that is all you need and a clinical person really needs to de-brief you. (P6)

Similarly, other participants reported seeking *support from external nursing colleagues* such as friends who were nurses working in intensive care:

I've also got some really good friends who work in other areas such as ICU so we catch up all the time and I find that is a really good debriefing. I just talk to other colleagues and friends and I find that is a really good mechanism for coping. (P12)

5.5.3.3 *Seeking support from family and friends*

The third component of *seeking personal support* was identified as *seeking support from family and friends*. Some participants took their experiences, trauma and emotional reactions home to debrief with their partners or respective family members and friends. This occurred as a result of limited opportunities to debrief with work peers or colleagues due to limited time and work load demands. One participant provided this example:

I think staff [theatre] nurses are a funny breed they don't talk when it comes to emotional work, they don't talk about things ... you might go home and talk to your partner, but I find at work everyone sort of stays a bit closed off. (P19)

Many of the participants reported that home was the safest place to seek support without being judged in a supportive and loving environment and that information at home was not going to go elsewhere. Taking it home also provided an opportunity to de-stress and off load to their partners what they had previously bottled up and kept hidden for numerous hours under pressure to perform:

I know it's confidential but I sometimes, I talk to my family, how I felt and what happened in the theatre. I don't say the patients name or anything ... just talking about it, [the procurement procedure] in general such as we had one of these cases. (P15)

For many of the participants', the after effects of their participation would be with them at the completion of their shift and they would often take any unresolved issues home. The need to talk to a partner about his/her thoughts was also expressed further by participants: "When, I'd go home, I'd still be sort of thinking of it [participating in the procurement]. It would be going around in my mind. I wouldn't go into specifics ... on occasion I'd talk to my husband" (P20); "I seek support more from my partner, from my husband I really talk to him about stuff" (P5).

I think I'm very fortunate because I'm married to another scrub [perioperative] nurse. So sometimes we talk to each other and we know exactly what we're talking about or even thinking. So, I think I'm very fortunate in that sense because he can understand where I'm coming from. I am fortunate that I have my husband to bounce things off and talk to. (P24)

Other participants felt that they could speak more frankly about their experiences and how they were really feeling with their partners, spouse or friends external from the operating room environment: "Just at the time I talked about it [the experiences in procurement] with a few people, friends ... and my partner. I was a bit of a wreck when I got home so I had to get that out" (P26). The same participant explained that her partner was better able to support her as he understood her compared to her work colleagues:

I [found] my partner a lot more helpful. One reason is that I find [long pause] I find that probably I think more differently than a lot of my work mates so I find that they may find me a bit hard to understand, from time to time, they are all like minded souls so they would not have understood my views. (P26)

A few of the study participants reported coming from a family of nurses. Therefore they would seek support from family members who were also nurses and had some nursing understanding of some of the situations they encountered during work. One participant explained:

I often talk with my family [members] that are nurses, and I can without mentioning names or anything or involvement or anything like that. I can say I had a pretty horrendous sort of day I had to do this particular thing

[procedure] or we have had a death on the table or the patient was only young or something like that. (P3)

This view was shared by another participant who described also going home and talking to a mother who was also a nurse or other work colleagues in different specialties removed from the operating suite. Taking issues home or away from work provided participants the opportunity to confront emotional issues and get it off their chest in a safe and non-judgmental environment. One participant reported the following:

Any type of emotional stress, I will usually go home and I will of course in terms of emotional stress I will go home and reflect with somebody or I'll ... call my mum because my mum is also a nurse so she's quite understanding in terms of you know these sorts of things. She's actually a very good resource person ... It's quite graphic [the procedure] ... I mean of course I maintain confidentiality. I do remember explaining to her [my mother] what it was like, just describing it to her ... [It] just sort of made it better ... It was like, I'd got it off my chest you know explaining it to her. (P33)

Similarly, another participant sought support from her family and husband rather than at work: "I went home and talked to my family and my husband about it [my experiences at participating], I debriefed with him [my husband]. I didn't worry too much at work about debriefing" (P5). Another nurse spoke of living with a work colleague and as a result she was able to seek support external to the work environment:

We shared a house together and we just talked about it [our procurement experiences] any time one of us wanted to talk about it, sometimes it was [talked about] over and over again. It made us feel better ... So we probably really helped each other by talking to each other about it. (P18)

Family was also reported as a major source of support within the scientific literature (Dixon et al., 2005; Pennebaker, 1993). Ekedahl & Wengstrom (2006) found that nurses often turned to their family and friends when they had concerns about their work. Talking about traumatic experiences was reported as being beneficial to an individual's well-being (Pennebaker, 1993; Regehr et al., 2002). Participants in the recent study by Shorter and Stayt (2010) noted the difficulties nurses experienced segregating one's personal and professional life when confronted with grief. A participant in their study stated: "It can sometimes spill over into your personal life, but I don't think you'd be human if you could switch off everything" (Shorter & Stayt, 2010, p. 165). According to Ablett and Jones (2007) study on hospice nurses, a participant in their study mentioned that having a good support system at home was vital to coping: "You have to have a good support system at home... a social life... other interests outside here, and I think that is very important" (p. 737).

5.5.3.4 Seeking pastoral care

The fourth component of *seeking personal support* was participants *seeking pastoral care*. Several participants reflected that they were quite religious and would seek personal care from their priest or minister from their own faith. Participants viewed that pastoral care

was helpful as they were good at listening, supporting and often encouraged people to talk freely about what was bothering them. Some participants also reported *seeking pastoral care* and support from the hospital chaplain after he had provided assistance and support to families of donors following a procurement surgical procedure:

We do have or did have a hospital Chaplin ... and he would often be around and we would be letting the relative's view the body in intensive care. The Chaplin could sort of help with all that sort of thing, counselling and support and things like that for the relatives and the [nursing] staff. (P25)

Seeking pastoral support was reported as helpful to participants as they could talk about their experiences, fears and views in a non-judgmental environment with the knowledge that what they disclosed would remain confidential. One participant explained that when they were given an option to seek support, the majority always went to the priest:

It depends who it is that you could talk to [or] who's on offer for you to go and chat to kind of thing ... it's a trust thing. We had a priest, a minister or a nurse and everybody went to the minister regardless of religion because he was genuinely a nice guy and it [the conversation] went nowhere. So if folk needed to chat we would go to him [the priest], nobody went to the nurse [colleagues]. (P23)

Within the literature other studies also reported that nurses would often seek support from a priest or a hospital chaplain. The survey study by Dixon et al. (2005) showed that when nurses were faced with the loss of a paediatric and adolescent patients they were very selective and discriminating in whom they utilised for support. For example, while 13 social workers were available for support within the study hospital, 32% of nurses chose to see the hospital chaplain. In the recent Taiwanese study by Wang and Lin (2009) a participant reflected that some people would go to a temple to improve their psychological well-being: "I have heard some people will go to temple after being with a donor or a dead person. If they don't do this, they will feel uncomfortable" (p. 282).

In this current study, maintaining well-being through pastoral care support and spiritual practice was important to participants. It assisted them with *preserving self* by experiencing personal spiritual growth and gaining a deeper understanding of putting their faith into practice. Several participants therefore found that getting support through this avenue assisted them to find meaning in their experiences from their participation in procurement surgery. One participant explained that she found it helpful to maintain her well-being by seeking support through her pastor and her church group who could administer to her needs through spiritual practice:

As I said I'm a Christian I've got a church group for support. I can go to them and talk to them without breaking [patient] confidentiality ... I can tell them that I have been in a stressful situation and they will actually come and gather around me and pray for me, sort of thing ... they'll process it, they administer to me ... sort of thing ... they will encourage [and] counsel me. (P25)

Similarly, Kociszewski's (2004) study on ten critical care nurses providing spiritual care to patients and families also emphasised the importance of personal spiritual care. As one participant stated in their study: "I must provide spiritual care for myself, in order to provide spiritual care to my patients, and then able to give it to their families" (p. 408). Moreover a participant in the study by Ekedahl and Wengstrom (2006) stated: "It is fantastic to live near a church ... I go in there to get peace" (p. 133).

5.5.3.5 *Seeking professional support*

The fifth component of *seeking personal support* was *seeking professional support*. For many participants, *preserving self* entailed *seeking professional support* such as a counsellor or psychologist to overcome their experiences of *hiding behind a mask*. Several participants felt that it was important to speak with someone to preserve self: "Sometimes ... you need to talk to someone, anyone ... even someone professional ... whereas if you walk out of here [the operating room] and you don't say anything to anyone it can eat away at you" (P3). Similarly another participant explained that after exhausting all other options, a professional counsellor was the last and only option:

Oh, it [the experience] just got too much and I just went no I can't deal with this anymore. This is a bit beyond me so [nervous laugh] so I'll go and talk it out with someone because my head was going to explode. (P19)

By *seeking professional support* participants were able to overcome their concerns and were able to find meaning by validating their experiences and putting their participation experiences into context. Several participants felt that *seeking professional support*, although not always available, assisted them to talk about work issues and roles in a confidential and private capacity away from the work place. One participant spoke of *seeking professional support* such as private counselling:

Absolutely ... it was better because it was non - medical [counselling] and they were not involved in it [the procurement surgery]. I sought it [help] privately ... because it was, I mean it was me dealing with my own personal feelings and I would rather not use the [counselling] services at work. (P19)

One participant with extensive theatre experience went against the status quo and organised for a counsellor to come into the operating room and support staff throughout the whole surgical experience. This participant reported the benefits of receiving professional assistance from a counsellor:

When I was working at the *[Name of Hospital] they had a counsellor on site and I remember the first one I did [procurement procedure] over at the *[Name of Hospital] and I found out about the counsellor and I said "Oh you've got a counsellor?" "Yes" And I said "Can I have the counsellor?" And they said "Pardon." I said "I want the counsellor up here in the theatre while we're doing this procedure." "Oh." And so she [the counsellor] turned up [to theatre] in the middle of the night ... and I said to her "You'll have to come

in so you can see what we are doing, what we are facing [when participating]”. (P29)

The researcher then asked the participant how the counsellor had experienced the observation of the procurement procedure herself and the participant stated that the counsellor herself required counselling:

Exactly, how was the counsellor? ... she was [nervous laugh] she said herself “I need counselling!” and we talked her through you know [the procedure]. It was funny, people are trained in their job ... her job was to look after this part of me [pointing to her head] and that’s what she’s trained for. However we had to help her recover. (P29)

Having the professional counsellor come into the operating theatre during the procurement procedure was reported as validating the experiences of the nurses. Witnessing the procurement procedure and having such a profound impact on the counsellor herself assisted these nurses to come out of *hiding behind a mask* and discuss their issues and concerns. Therefore the counsellor was effective in getting the staff to talk about their feelings and experiences: “She was extremely effective in getting people to verbalise what they were feeling and it’s very hard for people to verbalise and say gee I feel like shit” (P29).

As a result of *seeking professional support* and having the counsellor present at the procurement allowed participants to find meaning from their experiences as noted by the same participant: “Since I’ve had that experience of having the counsellor in the theatre with me I have no problem now [with participating in procurement]. Before that they were always horrific, they’re still horrific, but they’re bearable” (P29). Unfortunately professional support was not always available:

That was the first time and the only time, at that hospital that I’ve had counselling. Nowhere else in my entire career have I had counselling and that was the only time I felt good about doing any of the work that I did. I always felt terrible about the work I did. (P29)

Other participants as a result of seeing the benefits of *seeking professional support* would seek it themselves when and if it was offered: “I think I’ll go and seek professional support” (P31). Consequently, as a result of such effective and helpful professional support several other participants questioned whether it would be of benefit to them to try counselling:

For some [nurses], that have had counselling and it’s interesting they were always younger and there would be some traumatic event whether a patient died such as in procurement ... they were given counselling or they asked for counselling, they asked for the help and it helped them, they appreciated it. They [the other nurses] found it beneficial. (P30)

In summary, *preserving self* was conceptualised as the second stage of the basic social psychological process of *finding meaning* which had three distinct stages: *being resilient*; *nurse self care* and *seeking personal support*. Participants’ engaged in strategies to assist

them to cope and manage their experiences with procurement surgical procedures. Participants spoke of *being resilient, relying on established coping mechanisms* whilst at the same time *coming to terms* with the emotional impact of these procedures by *releasing pent up emotions* which they had kept well hidden whilst *hiding behind a mask*. Participants engaged in seeking assistance and support by coming out from *hiding behind a mask* by dealing with their concealed thoughts, feelings and experiences by *finding meaning* through their experiences in procurement surgical procedures. As participants moved into the third stage of the basic social psychological process of *finding meaning*, which was titled *coming to terms*, they were finally able to overcome the traumatic aspects of their work role and were *finding meaning* to overcome the problem of *hiding behind a mask*.

5.6 Stage 3: Coming to terms

The third and final stage of the basic social psychological process of *finding meaning* was conceptualised as *coming to terms*. In an attempt to overcome the basic social psychological problem of *hiding behind a mask*, participants were able to come full circle through their experience. This was achieved by confronting their professional work roles and the personal impact of being involved in procurement surgery. Participants were then able to gain some understanding from their experiences by placing this experience into perspective hence *finding meaning*. Three aspects of *coming to terms* were identified: 1) *placing the participation role into perspective*; 2) *honouring the donation wish* and 3) *assisting in preserving life for the greater good* (See Figure 5.5).

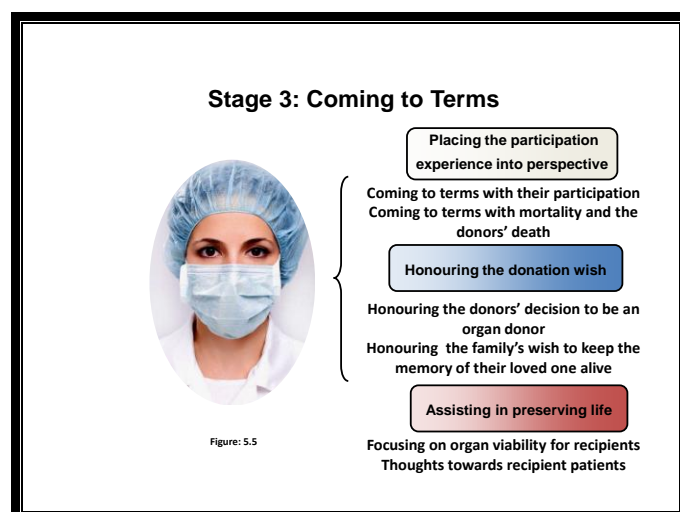


Figure 5.5: The aspects and components of coming to terms

5.6.1 Placing the participation role into perspective

Placing the participation role into perspective was the first aspect of participants' *coming to terms* with their participation in procurement surgery role and moving through the process of *finding meaning*. During this aspect participants were finally able to come to terms with their experiences both on a professional and personal level in relation to their participation.

Placing the participation role into perspective had two components: 1) *coming to terms with their participation* and 2) *coming to terms with mortality and the donors' death*.

5.6.1.1 Coming to terms with their participation role

The first component of *placing the participation role into perspective* was articulated by perioperative nurses' as the process of *coming to terms with their participation role*. Participants were able to reach this stage as a result of acknowledging and accepting that procurement procedures were likely to reoccur at any time within the operating setting and they may be asked to participate:

Personally ... there's an acceptance ... I feel that it's part of the job in theatre there are days when we have to do things that we don't like [such as procurement procedures], there are sad cases and horrible cases ... procurement is a sad one. (P12)

As a result of participants moving through the various stages of *finding meaning*, the problem of *hiding behind a mask* had lessened as nurses engaged in strategies to manage their experiences. Participants had become more resilient and had learnt from their experiences and were now aware of the significant roles they had played towards procurement procedures. For several participants, *coming to terms with their participation roles* did not happen after participating in just one procurement procedure. It took time for participants to come out from *hiding behind a mask* confronting their emotions and seeking support. At the time of the interviews, 27 out of the 35 participants were still at various stages of the process of *finding meaning* and coming to terms with their participation role in these procedures: "I could see that there was good going to come out of it, but it still took me a while to sort of to get over the initial shock of the surgery and the operation" (P20). As reported by another participant it took her one year and consecutive procurement experiences to feel comfortable. This participant engaged in managing her own well-being and seeking support and validation through other nurses' experiences:

It's almost like I had to get over this hurdle and after I got over that hurdle ... I think I have found them personally quite beneficial ... as I said it took me a year to get things right with me about what I was doing [participation] like what my actual role was and also ethically how I feel about this and that for me took, [long pause] took me a year and in that year [I was] talking to people about what was going on [inside me] and hearing their experiences that sort of helped. (P6)

Similarly for another participant with extensive nursing experience *coming to terms with their participation role* was not always easy and was revisited on several occasions throughout his career:

I suppose in later days, weeks and years thinking back on it, it always seemed to be well organised and for good reason, the processes were legitimate but it often occurred to me if the family had known how this sort

of process occurred would they have [donated their loved ones organs], if it hadn't been the relatives wish, would they have agreed to it? (P17)

For other participants *coming to terms with their participation roles* was achieved by *seeking personal support* from significant peers, family, friend's, clergy and other professionals. For one participant, his mother who was also a nurse was found to be helpful in assisting him to put his experience and the purpose of his role into perspective:

My mother, she was quite reassuring like that you know, she sort of reminded me that it [organ donation] was for a greater good and all these organs that are having to be procured would be going on to help many other lives. So she did reinforce that fact. (P33)

Other participants found *coming to terms with their participation role* when they could focus on the positive aspects of the role and their contribution towards assisting in these procedures. As explained by one participant this was achieved by focusing on the positive aspects of the organs giving someone a new chance of life:

I guess on reflection when I've done [assisted in these procedures] when I've been involved with those first couple as a scout nurse, I felt I kind of tried to focus on the positive aspects, that these organs were going off to be transplanted to give somebody else a better opportunity at life and so that helped me with my [long pause] accepting it ... as I say it wasn't as bad as I thought it was going to be. (P13)

5.6.1.2 Coming to terms with mortality and the donor's death

The second component of *placing the participation role into perspective* was articulated as perioperative nurses' *coming to terms with mortality and the donor's death*. It was a difficult process for the perioperative nurses to be confronted with death in the operating room as they viewed their roles as predominantly saving lives. *Finding meaning* from someone's death was not always easy to come to terms with as one nurse emphasised: "I can't believe this person was just, was punched and fell and hit his head and now look where he is. It's such a waste of life" (P14). Another participant reflected: "I just thought to myself this used to be a human being, this was a man who was breathing just a few days ago with his family and now he's just been taken from the world" (P20). Procurement surgical procedures were confronting for the participants but reinforced the need to come to terms with mortality and the death of their patients as there was no other outcome:

I guess more so, it made you think about your own mortality ... but you sort of look at your own mortality when you look at the age factor of donors and who they are harvesting from ... it just brings it home a bit. (P11)

For several participants, *coming to terms* with the donor's death occurred at different stages of the procurement process. For other participants *coming to terms with mortality and the donor's death* occurred at the time the anaesthetic machine was switched off. One participant described this experience as a finality: "Then the anaesthetic machine is turned

off ... I think there is finality about it then that you can register" (P8). This was also reported by another nurse:

In my experience it was when the monitor was first shut down. I can remember distinctly the silence and the silence just got to me. And it sort of dawned on me, oh my god the theatre is so quiet now, there's nothing happening and then you think this person has gone now [is deceased] that's it, [they're] already dead. (P22)

Several nurses were confronted with mortality and the death of the donor when they could visually see that the donor was no longer a whole person after having their organs removed. This took time for one participant to comprehend: "This person [the donor] is now no longer complete it was kind of, it took me a moment to digest that" (P6). As a result of the procedure being normalised, participants described the experience of facing the donor's death as a surreal experience: "It was just any normal operation it was like this is a little bit surreal because you know at the end of this [procurement procedure] he's [the donor is] not going to be coming out of it like normal" (P5). Other participants described *coming to terms with mortality and the donor's death* at the time of undertaking the last offices:

The last offices is the time ... I just realised this person [the donor] is actually dead. He's got nothing in his body left ... He's not going back to be recovered post op, he's just going to the mortuary. (P20)

Watching and experiencing the change in the donor's body also made participants come to terms with the donor's death and mortality in its physical form. One participant described this experience as: "They don't look like [themselves] even when they come in ... they are so cold and pale and I suppose its defining the fact [that] it's the end [the donor is deceased]" (P20). Another participant described this experience as having to come to terms with mortality and the donor's death:

I think what I [long pause] the thing that sticks clearly in my mind is actually just watching the change in the person on the actual [operating room] table when everything was like shut off. It was just the realisation like there was no life left in the [donor] person ... it was sort of a really eerie feeling to see the closure that comes over the person [donor] and that was more the impact [of death] and that still remains very vivid and it was almost like a veil that was shutting down, the facial features more so than anything else. We could actually see ... the changes in the donor's body occurring. (P11)

Other participants described witnessing this change when the surgical drapes were removed from over the donor's body:

It was a young boy, he was 18 [years old] ... this is the only reason it sticks out in my mind, when we took the [surgical] drapes off him and I just sort of looked at him and I thought geez he's skinny. And of course he's skinny we just took all his friggin [the whole lot of his] organs out ... that actually stuck in my mind. (P7)

This was also reported by another participant who provided the following experience:

When they take the things off [the surgical drapes] ... they really do not look pleasant there is no life in them and because of all the cold fluid used during the case and all the blood is drained they don't look like normal dead people. He's pale, they don't look normal they look just terrible ... that is the time you really see the [donor] person, is a person and then you really feel that feeling. I don't know how to explain it, it's like oh he's gone, it's like nobody likes to see a dead person and feel happy but when you see that. It's just kind of a feeling like oh my god he's gone his organs are gone. (P16)

For other participants, being confronted with mortality and the donor's death occurred at the conclusion of the procurement surgical procedure when the donor was waiting to be transferred to the morgue: "It's just that you have another process at the end of your procedure of laying out that person [the donor] and realising that that person is dead" (P8). Another participant provided this example:

In an empty room with a corpse ... so I actually find that not creepy but I find it a little bit unsettling ... we have to wait ... for the [donor] patients body to then be removed [taken to the morgue] ... I think it depends how you view death or how you see death if you like ... but I think you've just got to keep telling yourself that there was no outcome for this patient. They [the donor] were going nowhere [as a result of being deceased] you see I think you just need to sort of just remind yourself of that. (P4)

Participants were also able to overcome their experiences by *finding meaning* when reflecting that donors through their death were helping other people. Participants conveyed that a donor's death was not in vain and their decision to be an organ donor would save the lives of numerous others: "It is sad for the donor that he has died but I see it as a nice experience in knowing that they are helping other people" (P14); "But then in that they [the donor] are really helping other people and you try and justify it in your brain and you know, make sense of it all" (P19); "I think knowing that, you know, what's happening here [the procurement of organs] is [of] some benefit for somebody else" (P20).

For other participants, *coming to terms with mortality and the donor's death* and consequently *finding meaning* was achieved by rationalising the time donors had spent alive on earth. Several participants therefore conveyed it easiest to accept the death of donor's who were older as they rationalised that these donors had lived some of their life: "As I say the older the patient is the easier I find it is to accept it, [long pause] you know that they're dead, you know that they are going to do good for other people" (P10). Another participant stated: "It's like age [of the donor] does matter" (P16). Conversely as one participant explained she had to cognitively shift her thoughts in coming to terms with the death of a child donor by accepting that there was nothing that could have been done to change the outcome: "It was the most difficult case I had to assist in I think ... but there was nothing we could do ... to change the situation [the donor's death]" (P28).

The ability for participants to engage in the process of *finding meaning* from a donor's death and their ability to come to terms with this death was done by drawing on the strength of donor families when witnessing their resilience. Moreover the same participant reflected that coming to terms with the child donor's death and mortality was easiest when looking at the strength displayed by his own mother who was placed in a position of losing her son on Mother's Day. The participant reflected that if the mother could courageously make a decision to donate her son's organs, then in a professional capacity she should be able to come to terms with mortality and the donor's death:

I just, I think I really had thoughts for the [donor child's] mother you know the fact that she could make such a decision you know at such a time and the fact that it was also Mother's Day and you think "Oh dear". You know, how do you cope with that [referring to self], how does she cope with that, how does she cope with that sort of thing every Mother's Day. It's going to be, it's going to be upper most in her mind and things like that and he was just such a young boy. (P28)

Another participant also spoke of *coming to terms* and *finding meaning* when drawing on the strength of families coming to terms with their loved ones mortality:

The thoughts of life being so fragile, I mean I don't exactly remember the history of this lady but she was a mother of younger children and I couldn't help but feel bad for her partner and children and you know her whole entire family, that her life had been drawn so short. But then I sort of realised, what an amazing gift that she had given not only that, but her family had supported her in giving [being an organ donor] and I thought that was an amazing gift in that regard. (P33)

5.6.2 Honouring the donation wish

Honouring the donation wish was the second aspect of *coming to terms* with their participation in procurement surgery and moving through the process of *finding meaning*. Participants within this study were able to gain acceptance of the donor's decision to be an organ donor and were respectful of the family's need to carry out their loved ones wishes. As a result of witnessing this, participants were able to find meaning in their professional work roles by honouring their decisions: "It's, obviously what the donor wanted, that's what the family wants to happen so you have to obviously respect people's wishes and beliefs" (P10). *Honouring the donation wish* had two components: 1) *honouring the donors' decision to be an organ donor* and 2) *honouring the family's wish to keep the memory of their loved one alive*.

5.6.2.1 Honouring the donors' decision to be an organ donor

Honouring the donors' decision to be an organ donor was identified as the first component of *honouring the donation wish*. It was import for participants to accept and respect the donor's and their family's decision to organ donate: "This person [the donor] has made that choice and we are just honouring that choice" (P8). Once this was acknowledged

participants were able to shift their focus away from their own views and attitudes of organ donation to that of the donor's wishes and as a result moved through the process of *coming to terms* with their involvement within these surgical procedures: "So it's nice to know that something good will come from it. I mean we've all got to die and if something good can come from it I think it's great" (P28).

As another participant noted these decision were made away from the perioperative environment. Therefore, there was little that could be done when a donor reached the operating room: "Well, because somebody [the donor or the family] has already made the decision as the people [donors] come to the theatre. And there is nothing I can do about it and I have to learn to respect this decision as well" (P32). This was something that the donor had wanted to do such as leave their organs as a legacy at the time of his or her death and participants had to acknowledge and come to terms with this decision: "From a point of view of a person donating their organs ... it's their final gift and I think we should respect their decision, you know not only just their wishes but their body afterwards" (P33). With this knowledge participants were therefore able to absolve themselves of their own concerns or guilt at participating in these procedures as this was the donor and their family's choice. This point was illustrated by the following participant:

This is what he consented for so apparently as long as in the end we have honoured the patient wishes, like he [the donor] did what he wants to [in donating his organs] ... you do it [assist in the procedure] because there's nothing you can do about it anymore and ... like the patient has already gone [is deceased]. I think it's like, if he [the donor has] consented for that then we do it [the procurement procedure]. (P35)

Although participants found these procedures distressing they were able to come full circle from *hiding behind a mask* to reporting their participation in these procedures as honouring the donor patient's wishes:

I find it [the procurement procedure] distressing, but I don't think I would ever refuse [to assist in the procedure] because I think it's quite an honour if someone has picked you to do it [assist]. I think it's quite an honourable thing to do because you are respecting people's wishes. (P10)

For other participants having a better understanding of the procurement process and further knowledge of the brain death criteria assisted them to feel more comfortable in undertaking the procurement procedure and further honouring the donor's wishes. One participant described that as a result she had come to find the procedure to be rewarding:

It's very satisfying and rewarding because now I understand that the patient was brain dead well before [the procurement procedure]. I know that the family and usually the patient's wishes were adhered to, so it's something that they [the donor] actually chose and it's not a decision that we've made for them. (P12)

Moreover, participants within this study reported feeling a sense of pride in contributing their knowledge and skills towards not only honouring the donor patients and family's

wishes but in bringing closure in undertaking the family's wishes: "I felt quite honoured to be there and participate" (P5). This was described by the following participant as not only rewarding but satisfying professionally:

I think in knowing that I feel as if I'm doing [something] good, that ... we are carrying out the wishes of the donor and the family and knowing that what you're involved in [assisting in the process of procuring organs], is helping so many other people [recipients] and that's what gives me a sense of pride in my work and I think that also in itself gives me satisfaction in that you're just helping ... to bring that family and that person [the donor], that they have got a little bit of closure in that's what they wanted. (P15)

Another participant expressed the same sentiment:

But once I participated in it, I ... personally I thought I enjoyed like taking part in such like a good deed. I felt proud of myself in taking part in [the procedure] a little bit and to contribute my experience and expertise and help someone [the donor] to have [carried out] what they wished to do during their life and followed through with it. (P16)

One participant explained that in honouring the donors' decision to be an organ donor was an incredible experience to be part of:

Oh God it's, it's, it's really hard to verbalise it, it's sort of like you almost feel as though ... you are somebody taking a gift to [be] wrapped up to give to someone else [a recipient] You are [the perioperative nursing role] sort of, not even the middle person but somebody participating in an incredible donation of life to somebody else. (P34)

For other participants, having the support of the organ donor coordinator also assisted them in coming to terms with the procedure and the need to honour the donors' decision to be an organ donor. The organ donor coordinators were often the middle person who relayed the donors and family's wishes to the perioperative nurses. This was reported as helpful as it reinforced and reassured the participants of the need to follow through with the surgical procedure as the following quote demonstrates:

I have to say the co-ordinators are fantastic because they constantly reassure you that the relatives had consented to this [the procurement procedure] and try and focus on the positive aspects of it and that actually does help you get through it really initially. (P13)

A participant provided an account of a mother who had followed through the wishes of her young son which assisted the nurses to honour the little boy's wishes:

I mean that's what the mother had wished for ... his [the donor's] mum had wanted to [donate his organs] and I haven't actually spoken to the mum but had heard along the grape vine ... it's all second-hand knowledge but she

had spoken to her young son about organ donation and he had said yes he would like to do something like that. (P27)

Therefore, the organ donor coordinator was helpful in focusing on the positive aspects of the procurement procedure, the wishes of the donor and the positive outcomes for recipients. Several participants noted that the contact with the organ donor coordinator as extremely helpful in assisting them in *coming to terms with their participation roles* and *finding meaning* from these experiences with a positive focus:

It's just one of those things where you know good is coming out of it, but at the same time you know some people [the donors family] are sad but I think with this [the procurement surgical procedure], this is where there's always the joy in knowing that even though we lost our son or whatever we have helped other people. (P14)

For other participants *honouring the donors' decision to be an organ donor* was reported as a relief in that their death did not occur in vain and their donation would positively benefit others in need:

In knowing that now this persons [the donor's] organs, the organs that they are donating, they are going on to help somebody else [a recipient] ... so you get some sort of not a satisfaction but some sort of relief I suppose to know that his, [the donor's] death hasn't been in vain. If you can look at it like that and that [his/her] organs will go on now and they will benefit somebody else. (P20)

Several participants in honouring *the donors' decision to be an organ donor* suspended their own judgments about organ donation and were accepting of the donors' decision by reporting approval towards their decision: "Personally I think the person has done the right thing like donating the organs he ... or she is doing the right thing and somebody else is going to benefit from it" (P16). Other participants spoke of honouring the donors' decision with great admiration which reinforced to the participant the great sacrifice they had made:

I think at that time I felt great admiration, what a great man [the donor was] ... I just felt what a nice person to have agreed to donate his organs and what an honour for us [the surgical team involved in procurement surgery]. (P22)

Similar views were also expressed in the earlier study by Pelletier-Hibbert (1998) on intensive care nurses who also reported feeling "good" or a sense of satisfaction that the organ donor was able to leave the gift of life for someone needing a transplant and a sense of something good coming out of the donors' death by the procurement surgical procedure. The study by Wolf (1994) also emphasised that when patient's wishes were honoured this made participation less difficult for staff involved. As one participant in their study stated:

The patient or the family members have made this their wish. They have consented to this. This is nothing more to me than acting in accordance with everything else that you do with the patient. You are giving them what they have asked for. (p. 977)

In a broader context, the study by Ablett and Jones (2007) on hospice workers also reported care of patients at the end of their lives as a privilege:

For myself, I put it that there are two important events in anyone's life, and the first one is being born, and the second one is dying. And to be part of those processes is a privileged post to have so I find working in palliative care to be a privileged post to have really. (p. 736)

5.6.2.2 Honouring the family's wish to keep the memory of their loved one alive

Honouring the family's wish to keep the memory of their loved one alive was identified as the second component of *honouring the donation wish*. Participants were aware of the need for the family's of donors to keep the memory of their loved one's alive through the knowledge that their loved ones organs were living on in recipients through the donation process: "They [the family] know that part of their relative is living on ... is still alive and providing life for somebody else" (P17). In *honouring the family's wish to keep the memory of their loved one alive* participants reflected on engaging in activities such as cutting lockets of hair off the donor to give to parents as a keepsake: "We took a locket of hair to give to the parents" (P29). These activities were important to the study participants in coming to terms with the donors' death as it assisted them to give back to the donor and their families by continuing to honour their needs:

We would obviously follow the patient's wishes and the *[State Donor Coordinator] quite often talks to the family and finds out if there is anything in particular that they want us to carry out. They [the donor coordinators] are very good at handing that [information] over [to us] and we would make sure that we would try our best to make sure that that would happen for the patient and their families. (P12)

Other participants within this study spoke of undertaking activities such as taking young donors hand and foot prints as keepsakes to be given to the donors' parents:

Well I know with this young boy that we did [the procurement procedure] we took his handprints and footprints. So I thought that was very nice of the co-ordinator to do this, to give it to the parents. (P27)

These experiences, although tough to witness, assisted participants to place their experiences into context. Participants felt that providing parents with little keepsakes was the least they could do for the donors' family during this time:

I feel privileged in a way to be part of it [the procurement procedure] what an incredible person [the donor] to be giving this gift ... it's the least I can do

for the family. To me it's somebody is giving this incredible gift to someone else and unfortunately somebody has had to die for this to happen. Families could say no and you know when you look at that, it's the families who are the most incredible people because they're actually gifting these things of their children to help someone else. (P34)

Within the literature, other studies also reported nurses undertaking similar activities (Epstein, 2008; Williams, Munson, Zupancic & Kirpalani, 2008). Creating memories was also reported in the study by Epstein (2008) on end of life experiences of nurses and physicians nurses who care for children in the newborn intensive care specialty. Within this study 71% of nurses described end of life rituals such as "bathing" and "taking pictures" (p. 775). Similarly, Williams et al. (2008) also reported the importance of "making memories" and undertaking activities to create memories such as handprints, footprints, photographs and name bands in assisting bereaved parents in the grieving process (p. 338).

5.6.3 *Assisting in preserving life for the greater good*

Assisting in preserving life for the greater good was the third aspect of *coming to terms*. When participants focused on their professional roles in ensuring that organs were viable for recipient patients, this assisted them to place their roles into context. Focusing on *assisting in preserving life for the greater good* was a strategy used by participants to move on from the donors' death and their experiences. This strategy was used by participants in *coming to terms* with their participation in procurement surgery. Their primary focus was on procuring organs which were viable for recipients. When this could not occur, for whatever reasons these situations reinforced the required need for viable organs for transplantation. *Assisting in preserving life for the greater good* had two components: 1) *focusing on organ viability* and 2) *thoughts towards recipient patients*.

5.6.3.1 *Focusing on organ viability for recipients*

Focusing on organ viability for recipients was identified as the first component of *assisting in preserving life for the greater good*. Participants were able to come to terms with their professional roles and contributions towards procurement procedures by focusing on the positive aspects of undertaking a successful procurement procedure with vital organs. Several participants shifted their views *focusing on organ viability for recipients*:

I think there are so many people that need organs and if organs are good and they're just going to be buried or cremated or something well if they can give someone else a better quality of life then that's great. (P28)

As procurement surgical procedures only occur at the time of a donor's death participants had an opportunity in *assisting in preserving life for the greater good* whilst also *focusing on organ viability for recipients*:

So, I tend to feel when the opportunity comes you get a whole gamut of people [the procurement surgical team] involved who are going to have a

chance of either a recovery [of viable organs] and an improvement in their [a recipient patients] life and I think that's what everybody should focus on. (P4)

Focusing on organ viability for recipients was the prime focus of undertaking procurement surgical procedures. When organs were procured and they were not viable, although viewed as a failure, for the study participants this assisted them in *coming to terms* with the importance of the procurement surgical procedure and their respective roles. This occurrence brought it home for participants: "It was just disappointing ... she [the surgeon] was telling them [the procurement team] that it wasn't ideal because they couldn't use the donors' heart. However they could still take and use the heart valves" (P24). Participants felt defeated for the donor who had undergone the surgery unnecessarily as no organs were viable for transplantation. This disappointment was reported by one participant:

I remember one case that stood out, the young man was a 21 year old man, when they actually got in [the chest] they were hoping to take the heart but they found that there was something wrong with it, there was ... a mild infection around the pericardium so they had to abort taking the heart ... It was disappointing. (P25)

These setbacks assisted participants in *finding meaning* at consecutive procurement procedures in the hope that they would be successful. Therefore, out of these negative situations participants were able to come to terms with the general aims of procurement surgical procedures by placing these incidents into perspective.

5.6.3.2 Thoughts towards recipient patients

Thoughts towards recipient patients were identified as the second component of *assisting in preserving life for the greater good*. Participants were able to come to terms with their participation experiences in procurement surgical procedures by focusing on the needs of recipient patients: "It's about stages you know, we are there to help the next person [referring to the recipient] even though you know we are there to sort of still care for the donor" (P15). For other participants knowing that they were helping recipient was important to them: "I'm happy now to do that [participate in other procurement procedures] I could see that we're actually, we are doing something that is good here for recipients. It is going to help somebody else [the recipient]" (P6).

In participating in procurement surgical procedures several participants had *thoughts towards recipient patients* as a way of rationalising the purpose of their roles and the need for organs: "I can see the value in organ transplants there is lots of things [organs] you can harvest off" (P17); "Giving it [your organs] to someone else who perhaps can receive that gift of life ... I think is full on and to be helping recipients is amazing" (P21). Participants spoke of the debilitating circumstances of seeing recipient patients when they were coming into the operating room for consecutive surgical visits as a result of their declining health:

I'm a strong believer in organ donation. I think it's very rewarding because it has helped so many other lives because we [perioperative nurses] also see the [recipient] patients that are requiring these transplants and see how sick they are and the multi operations that they have had beforehand so to improve another person's [the recipient patient's] quality of life, I think is just an unbelievable gift. (P12)

Often participant's *thoughts towards recipient patients* were one of empathy as they were aware of their plight waiting for an organ to become available:

How debilitating that can be for recipients who are sick and waiting [for a transplant]. I don't have a huge amount to do with the cardiac patients but I would image it would be a similar scenario. I can't imagine how they must feel being on a list, waiting on a waiting list, you know just waiting for this to happen [an organ to become available]. (P4)

For other participants being involved in transplantation surgery reinforced the positive aspects of their professional roles. During these surgical procedures participants were able to see firsthand recipients' unhealthy and malfunctioning organs and the transplantation of a healthy organ. As one participant noted seeing the positive aspects of procurement surgery assisted nurses in *finding meaning* by weighing up the benefits of their participation experiences in procurements surgery in light of the positive aspects on recipients:

Being involved in transplant, definitely because you're seeing the positive side of it, you're seeing peoples' lives changed in the positive sense and you're seeing these organs that are being taken out and actually being then put in. So ... I think it's very much a positive [procedure] rather than, just having seen them [organs] taken out all the time. I think it's important to see the other side of it [transplantation]. (P34)

Thoughts towards recipient patients also occurred when receiving positive feedback from successful recipient stories. Hearing these success stories enabled participants to come to terms with the negative aspects of their participation in which they viewed as dealing with the death of the donor and undertaking the procurement of organs. However on hearing the positive outcomes of these procedures participants felt a satisfaction that they had played a small role in these success stories as a profession: "You are helping by being involved [in these procedures], you are seeing where these organs are going and you can see, you know that they [procurement procedures] are helping recipients" (P30).

Participants further reported having *thoughts towards recipient patients* when watching success stories on television shows: "More recently, I have seen interviews and shows like Royal Prince Alfred ... where you see the benefits of the gift ... and more recently in the paper where the family or the members of relatives tell their stories" (P17). This was also reported by another participant: "Places you see they [donor's] are helping [recipients] is usually in the women's magazine or the newspapers ... the place where we see whether things have been successful or not are in the newspaper unfortunately" (P30).

Several other participants spoke of receiving a letter of acknowledgement from the donor coordinator as a result of their participating in a procurement surgical procedure: “No we got an individual letter which made it seem really personal rather than just a multiple photo copied [letter] sort of thing” (P25). These letters provided some details on the progress of recipients from the organs procured:

They always send a letter through to those people [perioperative nurses] who have participated in the donors care [through the multi-organ procurement surgical procedure], to give you some follow up as to where the organs have been donated ... always keeping anonymity of the recipients but they give you an idea of the age and the location [state] of where the recipients are from and I think that always give you a little bit of a you know, a sense of for me, a sense of pride in knowing that you’ve helped those people [recipients] and it’s just nice to know that it comes full circle. (P15)

Appreciating the benefits of a procurement procedure was helpful to participants and assisted them in the process of *coming to terms* and hence *finding meaning* from their experiences: “So that was nice to get that feedback because you actually felt you know it kind of reinforced that this is a worthwhile thing we are doing” (P13). One participant explained this aspect:

Usually we get a letter, [for example], they [the organ donor coordinators] do tell us where the [donor] patients organs have gone to which is good and whether they [the recipients] are progressing well or not. I think it’s good to get that follow up because we’ve been involved in this [the procurement procedure] and it can be ... or could have been a traumatic procedure for some people. Also to say “I participated in that team” and know or get to find out where or how, what kind of success has been achieved for the recipient’s which is fantastic. (P1)

Moreover, other participants found receiving such news of recipient’s progress as important in how they viewed their own roles and participation in these procedures:

To me it is important to receive a letter because I look at it [participating in multi-organ procurement procedure] in that so many people [recipients] can get help from it [the donation of organs]. We’ve received letters from the co-ordinator to let us know ... how many people [recipients] ... have been helped by the procedure. (P28)

This was also reported by another participant:

Sometimes we get a letter back saying this one [this organ] went to this type of person ensuring confidentiality of the recipient ... “Oh this [recipient] is doing well” the organs were viable and transplanted successfully, so hopefully it will be good, it’s more confidential than anything. (P35)

In summary, *coming to terms* was conceptualised as the third stage of the basic social psychological process of *finding meaning*. *Coming to terms* had three distinct stages being 1) *placing the participation experience into perspective*; 2) *honouring the donation wish* and 3) *assisting in preserving life*. During the third stage participants' focus of their participation in procurement surgical procedures shifted away from their own concerns to those of the donor, the family and the recipient. Participants engaged in activities such as *coming to terms with their participation* role by honouring the donors and family's decision to be an organ donor. Participants were finally able to acknowledge the importance of their professional work roles in these procedures evidenced by the need for organs by recipients and the success stories which they had played a part in. As a result of *coming to terms* with their experiences and shifting their focus to the needs of recipients, participants were able to overcome the traumatic aspects of their work role by *finding meaning* to overcome the problem of *hiding behind a mask*.

5.7 Summary

This chapter presented the basic social psychological process of *finding meaning* which was identified as a process used by perioperative nurses to overcome the experience of *hiding behind a mask* as a result of participating in multi organ procurement procedures. Participants engaged in the turning point of *taking control* which was an internal process prior to engaging in the process of *finding meaning* which comprised of three stages: *pushing through*; *preserving self* and *coming to terms*. Participants articulated focusing on *pushing through* to complete the surgical procedure. Further, participants spoke of dissociating from their experiences by *suppressing hidden thoughts and feelings and being accountable for their practice and advocating for the donor patient*. Moving into the second stage of *preserving self* participants focused on *being resilient and relying on established coping*. Participants took time to focus on their own needs by *paying their last respects* to the donor and also *releasing pent up emotions*, leaving their work issues at work and *seeking personal support* from various sources. The third stage, *coming to terms* dealt with *participant's placing the participation role into perspective by coming to terms with their participation and coming to terms with mortality and the donors' death*. Participants engaged in *honouring the donation wish* by *honouring the donors' decision to be an organ donor* and *honouring the family's wish to keep the memory of their loved one alive*. Lastly participants engaged in the process of *assisting in preserving life for the greater good by focusing on organ viability for recipients and thoughts towards recipient patients*. All of these stages contributed to the identified basic social psychological process of *finding meaning*.

CHAPTER 6

Conditions Influencing the Basic Social Psychological Process of Finding Meaning

“Process is the same as change, the analyst first must specify what is changing as it emerges and then show what causes the change, if the data allows this analysis. The data may direct the analyst to the consequences of a change or the social psychological defense against or reaction formation to change” (Glaser, 1992, p. 93)

6.1 Introduction

In the preceding chapters, the basic social psychological problem of *hiding behind a mask* was identified as the problem experienced by perioperative nurses when participating in multi-organ procurement surgical procedures. In an attempt to overcome *hiding behind a mask*, the data revealed that participants engaged in the basic social psychological process of *finding meaning*. This chapter presents the positive conditions which were identified as influencing the perioperative nurse participants in *finding meaning* from their experiences when participating in multi-organ procurement surgical procedures.

6.2 Conditions influencing the process of finding meaning

The conditions influencing the process of *finding meaning* were identified within the data and facilitated participants' ability to move through the stages of the basic social psychological process of *finding meaning* and to overcome feelings of *hiding behind a mask* (See Figure 6.1). During this process participants were able to identify positive influencing conditions such as a changing work environment; feeling less isolated and being supported by their work organisations. In addition, participants experienced increased opportunities to gain specialist knowledge and experience in assisting with organ procurement surgery. Moreover, participants disclosed that there was a general recognition that these procedures had the potential to traumatically affect nurses therefore this acknowledgement led to increased levels of support. Three influencing conditions were identified within the data, these were: 1) *work conditions*; 2) *levels of knowledge & experience* and 3) *levels of support*.

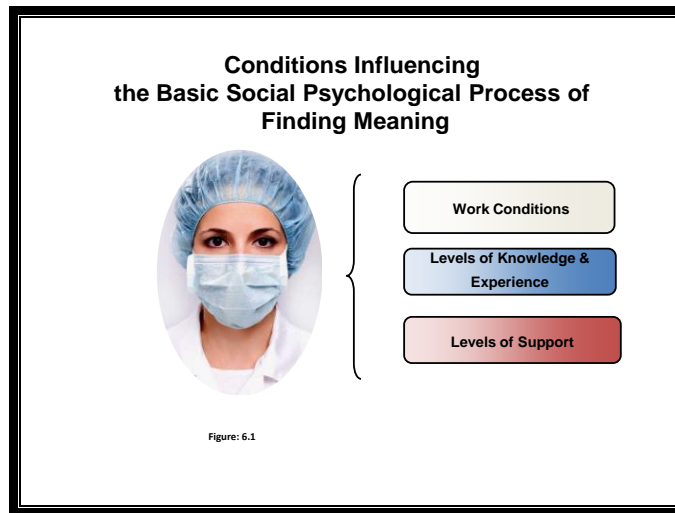


Figure 6.1: Conditions influencing the basic social psychological process of finding meaning

6.3 Work conditions

Work conditions were identified as the first condition influencing the participant's experiences of *finding meaning*. These *work conditions* were reported as positively influencing participants to come to terms with their professional role. *The two* components of work conditions were identified as: 1) *a change in work culture* and 2) *better work conditions* (See Figure 6.2).

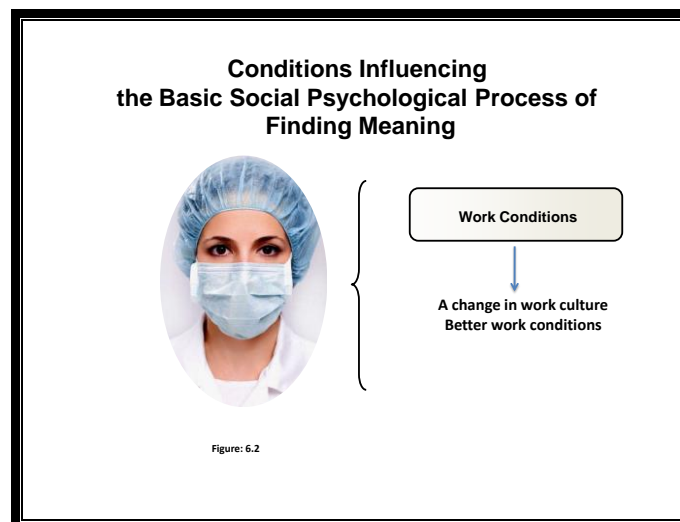


Figure 6.2: The components of work conditions

6.3.1 A change in work culture

A change in work culture was identified as the first component of *work conditions* which was reported as influencing the basic social psychological process of *finding meaning*. Several participants articulated that *finding meaning* in their professional role and their participation in procurement surgical procedures was largely due to *a change in work*

culture at their work place. This change in work culture encompassed an acknowledgement and acceptance of the traumatic aspects of participating in procurement surgery which then allowed nurses to speak openly about their experiences and the personal impact these procedures had upon them.

Participants in this study gave contrasting details regarding the historical nature of the perioperative nursing culture reporting that in the past perioperative nurses had to be stoic and resilient during traumatic surgical procedures while receiving little support within the working environment: “You know, in the past the older sisters expected you to just do your job, you really did just get on with it [referring to procurement surgical procedures] and as I say you were seen and not heard” (P10). Similarly, another participant provided this example:

In those days no ... there was no display of any emotion ... any display of emotion would have just been looked at not harshly but it would not have been accepted or acceptable like it is encouraged nowadays to vent or open up say what you think, say what you feel. Those days it was just do the job and if you’d come up and said “I feel upset about this or you know I really feel uncomfortable” you’d be told “toughen up princess or prince”. (P17)

However, participants explained that there was now a slow emergence of change within the workplace and culture within the operating room. This was evidenced by surgical team members being more accepting of perioperative nurses opening up about their concerns when participating in multi-organ procurement surgical procedures. Participants referred to their individual workplace cultures as evolving and becoming more accepting and supportive towards the individual needs of nursing staff when dealing with difficult procedures such as multi-organ procurement surgery. Nurses referred to this change in work culture and environment as conducive to promoting a supportive work environment with camaraderie amongst staff. This was articulated by the following participants comment:

I think the staff here in *[Name of Hospital], particularly *[Name of Nurse] and her team are fantastic ... they are extremely good and understanding. I think they are more aware today of the impact of procurement surgical procedures than they were perhaps in my day, they were more stoical in my day. (P10)

Participants who worked in these more progressive and accepting organisations reported improved interpersonal communication and team camaraderie as a result of improved work cultures. This aspect was described by another participant:

I think at the moment we are very lucky with the [surgical] team that we have here *[Name of Hospital]. I think there are a lot more supportive teams around now, and the culture is changing than ... some 15 years ago ... You maintain your professionalism ... but if there is an upsetting case [such as procurement] we are all more inclined to talk about it and talk about how we felt and stuff like that which is good ... we are more open now. (P18)

Moreover, several participants referred to *a change in work culture* as an attitudinal shift amongst perioperative nurses who began to feel safe enough to voice their experiences and concerns and to seek assistance. They were able to do this in an environment of mutual respect and understanding which positively enhanced their experiences of *finding meaning* when participating in procurement surgery: “Knowing, I had that support was helpful” (P6).

A change in work culture also found several participants beginning to “watch out for each other” (P9; P13; P28; P29), from experiencing potentially traumatic events in the workplace when participating in procurement procedures. These nurses’ felt it important to protect younger and less experienced nurses from being confronted with traumatic experiences, such as participating in organ procurement for the first time as it could hamper their efforts in *finding meaning* as a perioperative nurse. Several participants were well aware that *finding meaning* was a process that took time to develop and they did not want a less experienced nurses’ first experience to be overshadowed by a negative first experience. This was illustrated by the following participant:

You have to support each other ... Well that’s what happened with *[Name of Nurse] and I didn’t want her to be actually standing over it [the procurement surgical procedure of] the young child. I didn’t want her to see the heart stop beating. I didn’t want her to have that experience with the child you know, as she had young children herself. I wanted to protect her from that experience. (P28)

Within the literature other nurses were also reported to support colleagues within the work environment. An earlier phenomenological study of pediatric intensive care nurses’ grief experiences undertaken by Rashotte Fothergill-Boubonnais and Chamberlain (1997) found that nurses who had successfully adapted to the critical care work environment, did so by being knowledgeable about “who one could trust” (p. 376). Therefore trust amongst nurses was an integral factor in accessing “help” and gaining support from peers. Similarly, another earlier study by Hainsworth (1998) on the experiences of eight acute care nurses caring for neurologically devastated patients also emphasised the need to care for their colleagues by providing support within the daily work environment. A participant in this study made the following statement: “...we usually tried to support the nurse taking care of her by trying to give her a lesser assignment....” (p. 48).

In the current study, other participants reported offering to participate in a procurement procedure in order to relieve those nurses who did not or could not participate. As described by one participant this was referred to as an “understanding” amongst staff:

There are staff like *[Name of Nurse] who does the majority of night shifts, she just dropped back [her hours] to half time but she knows if she does not have staff for a procurement procedure, that she can call me even though I’m not on call. It’s just the understanding between staff that we have. (P29)

This change in work culture also promoted an attitudinal shift amongst surgical team members who tried to promote a caring environment, which emphasised an understanding

and acceptance of the individual needs of each surgical team member. This helped perioperative nurses to better connect with their colleagues and peers and enabled them to *find meaning* in their professional work lives. For some participants, this was expressed as *coming to terms* with their own limitations and the importance of disclosing this to their colleagues:

Knowing that your team, knowing your surgeon ... so that when you're doing it [participating in the procurement surgical procedures] then if you did get upset, I mean if you got upset there was absolutely no shame. It wasn't as though you had to hide it, hide the fact that you were affected emotionally. (P23)

According to Lindwall and von Post (2008), who investigated habits in the perioperative nursing culture, showing respect for each other created an atmosphere of harmony. As stated in their study: "Caring is given an increased value, both by senior staff and within the profession as a whole, so that nurses are clearly seen as professionals. They are then proud of their work and of the profession to which they belong" (p. 674).

In the current study, participant's further spoke of the emergence of DCD procedures and how *a change in work culture* promoted a shift in managers accepting that procurement surgical procedures were difficult procedures to participate in therefore accepting the need for support for nurses involved in these procedures. Several participants acknowledged that DCD procedures therefore brought to the surface the conflicting paradox of life and death and that in organ donation and transplantation a life has to end for donation to become possible: "Someone's life, the donor comes to an end ... I guess we all have to die eventually (P4); "Unfortunately a death has to occur for procurement to be possible" (P8); "The first day [referring to the time] we did a DCD procedure they the management always asked do you ... need any counselling services" (P35). Therefore the very nature of witnessing DCD procedures sparked a new level of cultural understanding, acceptance and acknowledgement of the experiences of nurses participating in these types of procurement surgical procedures: "In fact they've all [nursing colleagues] been very sympathetic you know and they've all said "How do you feel, are you feeling alright *[Name of Nurse]" (P20); "You make sure that people are alright you know you ask them ... 'How are you going?' ... 'Is everything alright?' " (P18). Having this change in work culture initiated a unified culture amongst perioperative nurses within their work environment.

Similarly, *a change in work culture* also allowed perioperative nurses to nominate whether they would like to be involved in these surgical procedures. Several participants felt relieved when there was an acceptance within the perioperative culture that one could conscientiously object to participating in procurement surgical procedures which fit the definition of a conscientious objection without being judged: "I'm glad we don't do people judging because everyone had the right to, to refuse to anything they are not comfortable with [reference to moral or religious grounds]" (P14). Several participants voiced that slowly this was occurring as nurses were becoming more vocal about their beliefs and rights to participate in the workplace: "Things are changing slowly ... I think the culture needs to be made within a unit that, it's okay to say no, I don't want to be involved in it" (P18).

Having this option assisted participants to come to terms with their decision to not participate when they felt procurement conflicted with their religious or moral values and this assisted them in *finding meaning*: “As far as I’m aware we are now able to say that we are not comfortable and I think we are able to say that yes we are not prepared to participate in those cases” (P11). Some participants reported that a list was put up in the theatre department which was used by nurses to report their intentions of not wanting to participate: “At some stage a list went up on the [theatre] board ... it was somewhere for people [perioperative nurses] to put their name[s] down if they didn’t want to participate [in a procurement surgical procedure]” (P8). This was similarly reported by another participant: “Yes people put their names up [on a list] if they didn’t want to, they could say I’m not comfortable with that ... for whatever reason” (P14).

Having an opportunity to conscientiously object to participating in procurement procedures was also reported as helpful to participants in *finding meaning* as it allowed them time to establish their own views on these procedures and determine when they felt they may be ready to participate. These participants were still able to find meaning even though they did not have to be involved in these surgical procedures. They reported the benefits they had witnessed when caring for recipient patients having transplantations procedures even though they found it personally difficult to participate in the procurement of organs from donors.

6.3.2 Better work conditions

Better work conditions was identified as the second component of *work conditions* which was reported as influencing the participants’ ability in *finding meaning*. Several participants articulated that when having *better work conditions* such as organisational support, adequate staffing and improved resources they were better able to respond to manage their professional work roles and the personal impact of these surgical procedures. These improved work conditions facilitated participants’ ability at *finding meaning* from their experiences.

Organisational support by managers and floor coordinators was reported as an important precursor in providing *better work conditions* for perioperative nursing staff when these procedures were required to take place. Participants spoke of various managers and floor coordinators who were aware of the need to consult with individual nurses and give them an opportunity to voice any concerns if they were required to participate in a procurement procedure. By having an open dialogue with their managers or floor coordinators participants felt more comfortable and at ease to disclose and potentially resolve issues which were of concern to them prior to their participation.

Several participants reflected that the ability to discuss various concerns with more senior managers or coordinators was invaluable as it allowed them to speak openly and honestly without being judged. At the same time, this provided an opportunity for managers to act on the concerns of staff members and implement such things as reallocating staff to meet the needs of the department and the individual nurse’s needs. Through this process of

acknowledgement, collaboration, understanding and support participants were able to engage in the process of *finding meaning*.

Several participants could not always participate in every procurement surgical procedure and they explained that when they chose to step away from participating, when they felt that they could not contribute they felt supported by senior staff. Such occasions were times when participants had experienced a patient death or the passing of their own relative and as a result they felt that they were not able to cope with participating in such a procedure at this time: “I had a relative that had passed away and I was grieving, it was difficult I wanted to avoid these procedures at this time” (P5). While some of these participants were clearly not personally able to participate in procurement procedures at the time these procedures were required, many could still see the benefits of saving lives through organ procurement. For one participant she clearly articulated to her senior managers that she could not participate in further procedures: “I would not participate again ... I just could not do it” (P26).

Better work conditions were reported as helpful to participants in managing both the physical and emotional impact of multi organ procurement procedures. Several participants spoke of bringing their problems to the attention of their organisations so as better work conditions could be implemented. As described in Chapters four and five, participants often had to manage increased workloads, staffing issues and limited opportunities to recover in between surgical procedures. This left them *hiding behind a mask* with increased stress levels and anxiety when contending with these workplace issues: “We finished a procurement one evening ... we still had other cases to do ... so the pressure was on us ... I felt like we didn’t have time to catch our breath ... it was just awful” (P25). One participant went to seek assistance from her nurse manager as she felt distressed as a result of participating in procurement procedures within the current work condition: “The work situation was too much ... something had to change ... this distressed me so much and this is after I’d done five of these procurement cases by that time ... it was difficult to manage” (P25).

When senior staff initiated changes which resulted in *better work conditions* being implemented in the workplace participants reported feeling supported and were able to *find meaning* from their work roles. One nurse provided evidence of *better work conditions* initiated in her workplace:

I actually went to my nursing unit manager who contacted our Director of Nursing and since then it’s been put in place that if we know that we have a procurement [surgical procedure] they [the operating room managers or coordinators] will organise a separate whole nursing team to come in [and undertake that procedure]. (P25)

As a result of acknowledging the needs of the staff, the same organisation initiated further changes to ensure *better work conditions* were available to their staff to enable them to better undertake their roles. These changes included modifying work roles, providing increased support during the procedure and increased recovery time between procedures.

This was noted by a participant who spoke of the Director of Nursing personally ensuring that staff were adequately provided for. She ensured that extra staff were sent to the operating room to accommodate the needs of the department to undertake other emergency surgical procedures and a recovery period for staff following their participation in a procurement procedure. This support also included providing food and drinks for staff if they were asked to work long hours. As the participant elaborated further:

Since then the Director of Nursing has said that they [will] provide food for us and the team that comes up they call in a separate team and that's an anaesthetic nurse, scout nurse and a scrub nurse and that's all we do [the procurement surgical procedure]. We stay with the patient when they come around [to the theatre]. ICU will bring them around and we usually accept them [the donor] at the [theatre entrance] door and take them to the [designated] theatre that's already prepared. The retrieval teams are already there to do the organ harvesting. Then [at the completion of the procedure] we've got time to actually help wash the [donor] patient and put them back onto their bed. We then wheel them to recovery [room], as sometimes the relatives still may want to view the [donors'] body after [the procurement procedure] ... the organ retrieval teams have gone ... sometimes they actually go around to a room in intensive care and the family might even be allowed to sort of come in there and view the body. So I feel like it's [this new process that has been put in place] a bit more organised and structured now ... and we have time to recover [from the procedure]. [This has been in place], now ... since maybe two to three years ago now. I've even been called in since ... this has been put in place; I've been called in on my days off to actually do just procurement [surgery]. (P25)

Other participants spoke of *better work conditions* being initiated within the operating suite by the individual and approachable leadership styles of floor coordinators or nurse managers. These managers developed an improved understanding of the emotional demands placed on nurses participating in procurement procedures. They became more caring towards staff and in their approach to managing concerns expressed by perioperative nurses. Several participants reflected that these managers had effective leadership styles that encouraged nurses to reach out and ask for assistance or talk about their concerns: "I think they [line managers] would be there to support you, if you felt you needed to go to them and cry on their shoulder" (P3). Several participants articulated that they knew which managers were more inclined to be supportive of their needs: "It probably depends on whoever is coordinating at the time and how supportive they are ... there is one coordinator who is really understanding and supportive" (P9); "You'd know who [which supervisor] to approach and who not too ... some managers are more understanding than others" (P29). Therefore floor coordinators were often the first people that were called upon when staff needed support:

The floor co-ordinators, they are there to support the running of each individual theatre so they're the port of call if you're having difficulties in your theatre. So if I was [assisting] in a multi-organ retrieval [surgical procedure] I would [seek support from], my first port of call is the nurse co-

ordinator, if I became unwell, felt I needed help or something like that ... They [the floor co-ordinators] would really look at it [the needs of staff] closely, the floor co-ordinator the middle managers that manage the situation. (P6)

Having this valuable source of support within the workplace was viewed as helpful to several participants. This support validated for them that they were able to come out from *hiding behind a mask* knowing that they would be supported and not be judged. The following participant viewed her manager as approachable and accommodating of her needs to undertake alternative duties:

And especially from our boss like she is pretty good [at supporting staff], like if anyone has got a problem in that situation [when participating in procurement surgery] she would say “Oh, okay then ... this is what we can do to help you ... we’ll put you in here [into another theatre to undertake another surgical procedure].” (P27)

Similarly, other studies also identified the need for better work conditions with social support in reducing work related stress (Amos, Hu & Herrick, 2005; Chapman, 1993). The Australian qualitative study by Schroeder and Worrall-Carter (2002) on perioperative nurse managers also identified that social support within the work environment alleviated stress and enhanced coping for nursing staff within this environment. According to Renzenbrink (2005) it is important for employers to provide a supportive work environment to its employees however it was emphasised that this should be managed by both parties if stress is to be alleviated.

In the current study, other participants observed improved *work conditions* as a result of conveying their needs to their respective theatre managers or to the hospital’s Director of Nursing. These nurses worked either in the regional or rural areas where they often lacked adequate resources and staff to undertake these procedures at the time they were required. As a result of obtaining additional work resources they conveyed that they were better able to cope with their work roles and their professional work demands and decrease their levels of stress associated with participating in procurement procedures. One participant spoke of the benefits of *better work conditions* helping her to feel more comfortable when assisting with the procedure and caring for the donor appropriately at the completion of the procedure. She had not previously been able to provide this care as she was usually overworked and had previously felt guilty about the amount of time she had to provide care following the procedure:

You wanted to stay in the theatre so that you could complete the whole surgical process, so you could take time to tidy the [donor] person up and give them a good wash afterwards and you then know that they were, well prepared [for the mortuary] I suppose. (P20)

Participants explained that they also experienced *better work conditions* when they had current and up to date resource manuals within their department to refer to when participating in procurement procedures: “We do have a better resource file now which

they've [the hospital and organ donor coordinators] have actually given us ... which is available for all staff to read" (P15). This enabled participants to be better prepared to participate and they knew they could readily access this resource file if needed. Having this available resource also decreased the anxiety experienced by younger or less experienced nurses as it allowed them the time to review the information within the file in their own time and be better prepared to assist in the procedure.

Other studies corroborated the current findings that *better work conditions* enhanced nurse's job satisfaction and improved their overall stress and work demands (Bartram, Joiner & Stanton, 2004; Chard, 2000). An American study by Leach, Myrtle, Weaver and Dasu (2009) when assessing the performance of surgical teams also identified similar findings of *better work conditions* however referred to this as "best-case" statements which accounted for the work environment and staff factors. These researchers identified that surgical procedures went well when nurses had better resources such as equipment, supplies and sufficient staff.

In summary, *work conditions* were conceptualised as one of the positive conditions influencing the participant's experiences of *finding meaning*. Work conditions encompassed two components; *a change in work culture* and *better work conditions*. Participants articulated that *a change in the theatre work culture* assisted them to be more open and verbal about the emotional effects experienced during procurement procedures. This also fostered improved interpersonal communication and an accepting environment for perioperative nurses voicing an objection towards being involved in these procedures. This allowed nurses to come out from *hiding behind a mask* and to find meaning in the work environment. *Better work conditions* encompassed organisations and managers instigating support resources such as adequate staffing levels to undertake these procedures. In turn this meant staff had the time to care for the donor and time to recover from their involvement in these procedures. This promoted an opportunity for participants to feel supported and hence they were better able to find meaning from their participation experiences.

6.4 Levels of knowledge and experience

Levels of knowledge and experience was identified as the second condition influencing the participant's experiences of *finding meaning*. Two components of *levels of knowledge and experience* were identified: 1) *having prior knowledge and experience with procurement procedures* 2) *sharing knowledge through team mentoring* (see Figure 6.3). Having some prior *levels of knowledge and experience* as a perioperative nurse was found to be helpful when participating in a procurement surgical procedure. Although the procedure was emotionally challenging for several of the perioperative nurses they could always rely on their acquired perioperative knowledge and their experience to see their way through the traumatic aspects of the procedure. Participants also articulated *finding meaning* through *sharing their knowledge through team mentoring*. This gave participants a purpose and an opportunity to work through their own issues whilst sharing their varying *levels of knowledge and experiences* with others.



Figure 6.3: The components of levels of knowledge and experience

6.4.1 Having prior knowledge and experience with procurement procedures

Having prior knowledge and experience with procurement procedures was identified as the first component of *levels of knowledge and experience*. Nurses who had worked in the operating room environment for several years had some prior exposure to procurement and were better able to cope with the technical nature and emotional demands of assisting with the surgical procedure: “[Perioperative] nurses with a degree of previous or prior [procurement] surgery experience would be able to cope better ... with these cases in whatever roles scouting or scrubbing” (P13). This was reported by several other nurses, in particular illustrated by the following participant’s response: “I felt that I was a little bit more prepared as opposed to someone [a nurse] who was only perhaps [had] eighteen months experience. I was better able to cope as I had more theatre experience at this time” (P15). Similarly, participants explained that *having prior knowledge and experience with procurement procedures* enabled nurses to be better prepared and understand the procurement process: “I had been a bit more experienced in theatre [and] in nursing. I think this helped me have a better understanding of the process. I believe it [assisting in procurement procedures] should be left to those that have a bit more theatre experience” (P13).

Of the thirty five participants, those working in the metropolitan areas reported higher *levels of knowledge and experience* of assisting in procurement procedures due to the frequency of the procedures being completed in metropolitan hospitals: “I have been involved with multiple organ procurement [surgery] ... multiple times probably approximately ten times all here at *[Name of Hospital]” (P12); “The multi [organ procurement procedures], I’ve participated ... I would say it could be up to 20 [cases]” (P6); “I’d say less than ten [cases] but I can’t be sure it could be more or [it] could be less” (P7); “Probably about eight [procedures] or more ... the very first couple of organ procurements that were done here at *[Name of Hospital] I had to organise it and work out what they wanted and I got involved in those [surgical procedures]” (P3). Three study participants

reported having participated in approximately fifty procurement procedures within their perioperative nursing career. All of these participants noted that as a result of their consecutive experiences they were able to move through the process of *coming to terms* with their professional roles and to find meaning from their experiences and participation.

Participants from the rural or regional areas acknowledged the importance of *having prior knowledge and experience* with procurement surgical procedure. These nurses had less experience with procurement surgical procedures thereby finding difficulty in *finding meaning* following their participation after just the one experience: "I've only ever had the one experience so it's hard to say how I would feel and experience it [participating in procurement] the second time around" (P24). Other nurses reported that they experienced delays in *finding meaning* as it took time to comprehend each experience they participated in: "I've been involved in four multi-organ procurement procedures and it took time to come to terms with my participation in each of those procedures" (P28).

Having prior knowledge and experience allowed participants to compare each individual experience as well as the collective experiences of others. However, they reported that *finding meaning* was challenged frequently with each new experience: "I sometimes still have difficulty coming to terms with assisting" (P1); "I think it's still confronting, I do!" (P30); "I always struggle with doing them [participating in multi-organ procurement procedure] even after all this time" (P25). When asked by the researcher if their previous experiences had helped, participants elaborated that experience was viewed as beneficial: "Your experience accounts for a lot, doesn't it ... you know we are all experienced theatre nurses and we just, [it] almost becomes like it's a routine thing now when you're involved ... I understand the process now and it's easier ... to accept it with more experience" (P13). Similarly, another participant provided the following viewpoint:

I think after doing it [being a perioperative nurse] for 30 years you can do a lot of things almost rote ... the actual clinical aspect of the [procurement] case like getting your instrumentation ready and all that I think that becomes a little bit easier because you know what they need, so therefore it's a little bit less frantic in that way, but the patient's [death and circumstances still affect you], it does, it's still a different person so there's always that aspect that affects you. (P34)

Participants explained that each experience made the next participation process a little easier as they had gained experience and also established ways to tackle the technical and sequential stages of the procedure: "The second one I knew ... the sequence of events" (P14); "It was better the second time I participated. I had a better understanding of what was happening [the procurement surgical process] because I had such a horrible experience the first time" (P18). Having this knowledge and experiences was helpful to participants as they could then focus on managing their emotional reactions to the event which needed to be processed and overcome before they could find meaning. Participants who had time available to reflect on their participation were more able to find meaning from their experiences.

With each new experience participants felt better prepared emotionally to manage the often traumatic experiences surrounding the procurement process: “Well [I] had to, I only relied on my experience ... just all my theatre experience ... to get by” (P25); “No [I] just had to rely [and] focus on my years of experience in theatre” (P3). Relying on their previous theatre experience was seen as helpful to several of the nurses when assisting as it gave participants the opportunity to work through their personal issues of *finding meaning* from their experiences in a broader context.

Participants who had increased knowledge about all facets of the organ donation and transplantation had a better understanding of the procurement surgical process and found this knowledge helpful. Several participants explained that their increased level of knowledge was a result of self-directed learning in the area which had assisted them in *finding meaning*. Other perioperative nurses had also undertaken professional development courses such as the Australasian Donor Awareness Program (ADAPT). This workshop has been funded by the Australian Government since 1991 and is available to health professionals such as, organ donor coordinators, doctors, nurses and social workers (Organ & Tissue Authority, 2010). Several of these participants met with a variety of health professionals whilst attending these courses: “There were nurses, there were surgeons, [and] there were ICU consultants” (P21). Participants, regardless of their levels of experience and the amount of times they had been exposed to participate in a procurement procedure, found the additional knowledge gained from these workshops beneficial as it aided their understanding of the organ donation processes:

Yes, I went to the ADAPT program, I did that because I wanted to know more and I think that is the only thing I did ... I think it was a single day course, a full study day but that was well after I had done probably the majority of retrievals or organ procurements that I’ve actually done already and I chose to do that. (P16)

Increased knowledge and understanding also assisted participants to feel more comfortable with their roles in procurement surgical procedures. As noted by the same participant she was able to benefit from attending the ADAPT workshop as this had increased her awareness and knowledge about the organ donation process in general:

I’m much more comfortable with it [assisting in the procurement surgical procedure] now because before ... I didn’t have an awareness of what was exactly going on throughout the whole procedure and now with my education and training I have a greater understanding. (P16)

Some participants increased their knowledge by not only attending the ADAPT workshop but by agreeing to be seconded to the ICU to specifically gain extra work experience in caring for brain dead donors prior to their procurement procedures. This experience was viewed as helpful as the nurse was able to witness brain death testing and to witness firsthand how other health professionals worked with the families of donors prior to donor patients coming to the operating theatre. This prior experience was reported as being beneficial as noted by the following participant:

But now I understand that the time of death actually occurred long before that and the actual family would have been involved with the [donor] patients' [confirmation of brain death] in ICU [intensive care unit] and all that. Also after doing a bit of education on the [Australasian Donor Awareness Program] ADAPT [workshop for health professionals] as well. I also got to see the roles [of other health professionals] before and after in particular in ICU and how they care for the [donors'] family and what [care] they provide up there and that also gave me a lot of satisfaction and happiness to know that, that [the donors family] is taken care of before and after [the procurement procedure] and I met a lot of the people who actually work for *[A State Donor Agency] and you know to ... see the effort that they actually put in. (P12)

Other participants in attempts at *finding meaning* wanted further exposure in these surgical procedures so as they could confront any personal issues head on. These participants spoke of requesting additional experiences in the procurement process. Often these nurses had stepped into these procedures whilst relieving night duty staff and they felt that they were unable to come to terms with their participation as a result of not participating in the procedure from the commencement. This was noted by one participant:

If I wanted to do it from the beginning [commencement of the procedure] I'd have to ask them [the manager or floor coordinator]. I'd ask, "If you have a [procurement] case, can you give me a call as I would like to come in and do this" ... It was more for me ... I wanted to do this (P16).

Having prior experience and exposure also allowed participants to focus on the objective of the procedure and the value of the organs they were assisting to procure: "So I was focusing on the anatomy and that is a fantastic positive side of retrieval ... Four to six folk can benefit from this and on an individual level, it's fantastic [seeing the] anatomy and the nurses to have such an opportunity to view this ... it puts the experience into perspective" (P23). *Having prior knowledge and experience with procurement procedures* was viewed as beneficial for several of the participants as a way to gain greater understanding of the procurement surgical process and their ability to manage the surgical procedure:

I think as far as I'm concerned, for me professionally anything that I haven't done before is obviously a learning experience and something that I can gain knowledge from and it's kind of like I have a better understanding, I can cope better because ... [I've] 'been there', '[I've] done that', I've participated in one of those [procurement procedures] and I know exactly what happens and I know what procedures to follow the next time I am involved. (P14)

6.4.2 Sharing knowledge through team mentoring

Sharing knowledge through team mentoring was identified as the second component of *levels of knowledge and experience*. Participants articulated that they found sharing *their knowledge through team mentoring* helpful in *finding meaning*. This gave participants a purpose and an opportunity to work through their own issues whilst also sharing their own

knowledge and experiences. Several nurses were appreciative of others sharing this knowledge. As noted by one participant sharing knowledge was often important as some participants were reluctant to seek mentoring due to *hiding behind a mask*: “I think any education that you give anybody is valuable whether they think they need it or not, often they do” (P4).

Several participants articulated that they were always ready to lend a helping hand to others less experienced, or to navigate through the process of procurement surgical procedures. This occurred as a result of having had nobody to provide this at the time when they had first participated. They recalled their own experiences and wanted to ensure that other nurses had more positive experiences than their own:

I just tell them [other nurses I am mentoring] about my experience and even though it was quite a long time ago I like to give them a little bit of a heads up with what happens and how I felt [when participating]. So I like to tell [them], to warn people [other nurses] because I don’t know whether the supervisors or anybody else does ... I know with my own experience I never had anyone support me at that time. (P24)

Several participants who engaged in mentoring other nurses found this role fulfilling and meaningful. They had an opportunity to make a remarkable positive difference to other participant’s experiences when participating in procurement surgical procedures:

Professionally, I feel that if I can help other people who have never experienced this [procurement surgery] and ... help them be involved and find it a positive experience for them, [then] that’s something that I have enjoyed helping others get through the procedure. (P15)

Historically, *sharing knowledge through team mentoring* occurred as a result of select nurses being offered training towards procurement surgical procedures. These participants explained that this occurred at the time multi-organ procurement surgical procedures were first established to take place within operating rooms: “I’ve had to teach because like I said I was, I was involved in the first several procurements we had done here at *[Name of Hospital]” (P3). These nurses had a responsibility to share this knowledge with other nurses: “The people who were actually trained or have participated in organ retrieval over in [Name of State] they were the ones who passed their knowledge down [to others] within the theatre environment” (P8).

Mentoring colleagues in the context of procurement surgery only occurred at the time a procedure was taking place. Therefore, mentoring experiences were only provided for the duration of the procedure. Some participants reflected that often mentoring would occur informally during night shift when staff were available; to talk less experienced staff through the procedure. Several of the nurses were grateful towards their fellow nursing colleagues during these times: “When some people would come onto nightshift ... they would come to learn and then be exposed to a retrieval [procurement surgery] sometimes you would have to show them what to do ... you appreciate that help” (P3). As noted by

one participant having the support of experienced nurses made participants feel more comfortable with their participation:

I've worked with *[Name of Nurse] who has been doing hearts for many years and so she and another * [Name of Nurse] they both knew what they were doing, they'd done them so many times before ... so that was fine. They were able to talk me through it [the procurement surgical procedure] so I wasn't thrown in the deep end on my own. I had that support in the theatre and I found it useful. (P19)

The sharing of knowledge and mentoring was provided by perioperative nursing colleagues and by the donor coordinators who were in attendance at each and every procurement procedure: "The donor co-ordinators were there, they guided you as best they could, as they had their own roles and it was very helpful" (P14). Other surgical team members such as procurement surgeons were also reported to assist perioperative nurses with informal mentoring and guidance of their needs throughout the surgical procedure which was reported as helpful:

Sometimes surgeons would talk me through it, [the] procedure ... especially [during the stage of dissecting] the heart and lungs. [Surgeons would tell you] like "When we cut here [the dissection of organs] there will be a lot of blood, so make sure you have your suckers ready and you know these clamps are needed now [motioning to an imaginary mayo table and equipment]. (P9)

Similarly, this provided participants with an opportunity to not have to hide behind a mask their own lack of knowledge and understanding. Participants felt comfortable with their mentors and colleagues to express this when they required some assistance. Having this available to them helped them to feel more comfortable and relaxed in a stressful environment:

I'm not afraid to say it at the moment, to colleagues that you know "Look I'm not very confident with it [assisting in a procurement procedure] can you give me a hand or stick close by you know advise me [on what to do next] or whatever." So I'm quite happy to do that I always make it known that I'm not 100% comfortable with something but I will do it. (P5)

Several participants as a result of having had such a positive experience whilst being mentored through a procurement procedure wanted to ensure that they provided the same opportunities, care and understanding to their fellow colleagues. As procurement procedures did not occur on a regular basis, several participants took these limited opportunities to mentor others who may not get another opportunity presented to them, to participate:

If it was my role to do so [to be involved in the procedure] I would have [to] but I would also allow the opportunity for somebody else to experience it if they wanted to as well. I could talk them through the procedure. (P24)

Moreover, some participants when mentoring staff tried to ensure that younger nurses were fully prepared prior to assisting as a scrub nurse. A participant who was an educator disclosed that as a result of staffing issues and limited mentoring opportunities she would not allow junior nurses to undertake the role of the scrub nurse in procurement procedures. This was to ensure that they were fully comfortable with their roles so as their experiences were more positive:

I always, the few times that I have had that [junior staff being asked to scrub for a procurement procedure] ... I won't let them scrub for the first time because I think that's too confronting. I'll be brutally honest I do think that's too confronting. I'd like them to scout for one or two [procedures] at least before they have to scrub [and assist]. (P29)

Other nurses also spoke of sharing not only their clinical experiences through mentoring but their knowledge that they had gained through further education and training. Several participants felt that in sharing their knowledge this had to be up to date and accurate. Therefore these participants sought and attended information from the ADAPT course to ensure that they were teaching and mentoring correctly. One participant reflected upon the benefits of receiving further education and training when *sharing knowledge through team mentoring*:

With my education and training, I feel now that I can actually teach the staff that are working alongside me whereas when I first started I was learning a lot myself so I couldn't actually be involved in the teaching role. (P16)

Sharing knowledge through team mentoring also occurred through the process of witnessing a procurement surgical procedure. This provided an opportunity for nurses to "see one [a procurement procedure]" (P29) and an opportunity to discuss pertinent events throughout the surgical procedure. Mentoring also occurred when participants were allocated to witness a procurement surgical procedure. This experience was viewed as beneficial as nurses had an opportunity to discuss events throughout the surgical procedure prior to having some involvement in a clinical capacity however this was not always possible due to staff shortages. One participant reflected on the positive benefits of having such an opportunity:

The first one that I ever actually saw was when I came through as a grad [graduate nurse] and I was very new to the theatres and it was actually suggested to us that we go in [to theatre] and observe [the procurement procedure] because they felt that it would be beneficial and educational for us to actually observe the procedure. So we were allocated in there [the theatre] for the entire duration of the harvesting of the organs and then we actually requested that we follow that person [the organ donor] patient down to the mortuary just to follow the complete surgery through ... It was so meaningful to observe it firsthand. (P11)

Initiating comprehensive training and mentoring amongst health professionals involved in procurement surgical procedures or dissection was also identified as necessary within the

literature (O'Carroll, Whiten, Jackson & Sinclair; 2002). The study by Essman and Lobovitz (2005) identified a lack of education and knowledge on organ and tissue donation amongst medical students. These researchers initiated an interactive course which covered the theoretical knowledge gaps of medical students on organ donation and transplantation. In addition they covered training to ensure that their medical students felt professionally comfortable with the process and procedure of procurement surgery. One way they achieved this was to provide medical students the opportunity to observe the entire donation process from the ICU to the operating room. Several of the participants within this study reported that they would highly recommend the education to fellow students as it was viewed as beneficial in the clinical environment.

Within this study, participants highlighted that more should be done to ensure that perioperative nurses had adequate exposure and mentoring opportunities in procurement surgery. Several nurses wanted the opportunity to provide better mentoring opportunities to theatre staff and increase education as they viewed this as vital to understanding their roles and helpful in *finding meaning* from their experiences:

There needs to be education. I think you could do education for these [procurement] cases at different levels and I think some basic education of what to expect would be helpful [to perioperative nurses], whether that [education] would be done internally within the department or whether that could be done by the [organ donor] co-ordinators [when they visit the theatres]. (P13)

Other participants were of the view that nurses should be gradually introduced to procurement surgery with mentoring which included an opportunity to step back from their role should their participation become too distressing:

I think you need education, like educating the junior nurses, this is what it's all about and if you ever want, if you want to participate in one you may go in and participate but once it gets too much for you, you can have the option just to walk out [of the theatre]. (P21)

Overall sharing knowledge through team mentoring was highlighted as a positive factor for several of the participants as it helped them to share their own experiences and to connect with other perioperative colleagues who may not have had adequate understanding of the process. As one participant illustrated she wanted to ensure that other staff had adequate knowledge and information:

I took it upon myself because nobody knew anything about like the set up for organ retrievals and they were just making a big mess of it all ...They needed help as they did not understand the procedure and what they needed. So I thought I should take it upon myself to do it. ... well everyone knows that I'm the link person to come to when it comes to organ retrieval. I do want to make like a little package up for the staff members you know [about] what organ retrieval is all about and DCD once it [these procedures] comes in. So I'm just going to work like in the next few months to get this prepared. (P21)

In summary, *levels of knowledge and experience* was conceptualised as the second positive condition influencing the participant's experiences of *finding meaning*. *Levels of knowledge and experience* encompassed two components; *having prior knowledge and experience with procurement procedures* and *sharing knowledge through team mentoring*. These components were conceptualised as positively influencing the participant's experiences of procurement surgery. Participants articulated that *having prior knowledge and experience* assisted in better understanding the procurement procedure and hence *finding meaning* through their participatory experiences. *Sharing knowledge through team mentoring* allowed participants the opportunity to assist others to navigate through the procurement procedure. Several nurses felt that this positively enhanced their procurement surgery experiences and hence they were grateful and appreciative as it aided in *finding meaning* from their participation experiences.

6.5 Levels of support

Levels of support were identified as the third condition influencing the participant's experiences of *finding meaning*. Two components of *levels of support* were identified: 1) *intraoperative support* and 2) *teamwork united as one* (see Figure 6.4). As described by participants increased level of *intraoperative support* and *teamwork united as one* assisted participants to accept their professional roles in procurement surgery and knowing that they had team support was of great value to them. Several participants reported that when they felt they had *intraoperative support* from their fellow colleagues, such as from perioperative nurses, the organ donor coordinators and procurement surgeons they were better able to cope and come to terms with their involvement in each procurement procedure with more positive personal experiences. When participants worked collaboratively with procurement surgical teams and organ donor coordinators they felt more unified as a surgical team working towards one goal and one purpose. This sense of *teamwork united as one* assisted participants in *finding meaning* in their professional roles and from their own participation experiences.

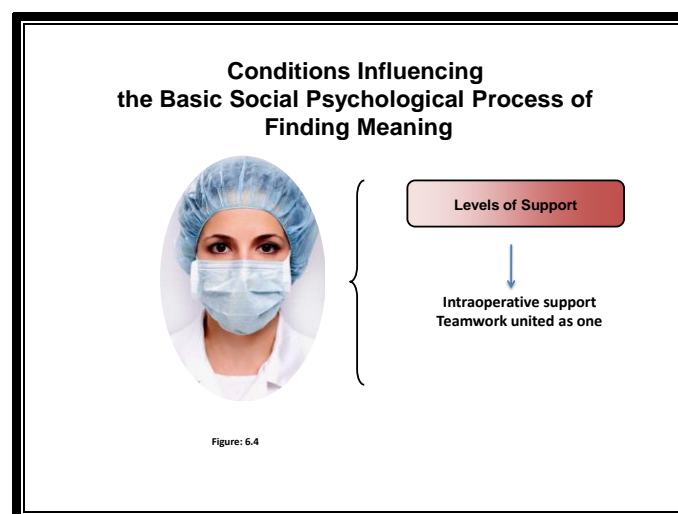


Figure 6.4: The components of levels of support

6.5.1 *Intraoperative support*

Intraoperative support was identified as the first component of *levels of support* which was reported as positively influencing participants' ability of *finding meaning* when participating in procurement surgical procedures. Several participants articulated that although the multi-organ procurement surgical procedures were intense, busy and very hectic, they found that surgical teams as a whole tried to promote as much as possible a calm and respectful theatre environment for donors and the surgical teams involved: "It was always a convivial atmosphere" (P8); "It was a calm atmosphere" (P6). This aided to unify the team by valuing each individual surgical team members' roles and establishing a comfortable and respectful work environment. Participants articulated that they felt more at ease with their professional participation roles in procurement surgical procedures as a result of experiencing positive *intraoperative support* from their surgical team members. Participant emphasised that when they received *intraoperative support* it was helpful to them as it reduced their levels of stress whilst participating often under difficult circumstances:

Well I found them [the procurement surgical teams] very ... they were very conscientious of creating a calm atmosphere. I mean even the medical team they were very nice, very pleasant, very conscientious of making a nice atmosphere in the theatre. They were just sort of talking and making it [the procurement surgical procedure] seem like a normal situation which was nice ... because it sort of calms you down a little bit. (P18)

Other participants described the operating room atmosphere at the time of an organ procurement surgical procedure as a different or sacred procedure compared to other surgical procedures. *Intraoperative support* was therefore directed at maintaining a very respectful and dignified atmosphere for not only the deceased donor but for the surgical team members involved:

The ones that I have worked in [participated in] it's a different, it's I suppose sacred is the word ... It is a different atmosphere but there is none of the panic you know, there is no panic with it at all. It is something that they have got to do and then they [procurement surgical teams] treat the patients with as much dignity and respect as you can. (P20)

When *intraoperative support* was initiated in a respectful manner towards donors and surgical team members involved, this was viewed as positively enhancing participants' experiences in procurement surgery and their ability at *finding meaning*: "They [procurement teams] treated the patient like a person and you know I think if it was any different ... it might well have been a bit more difficult for me to accept" (P20). This view was also reflected by another participant:

I was lucky enough to work with a team where they were all very respectful. You know the [donor] patients came in, there was silence, so there was just like an acknowledgement and unconscious kind of silence, an acknowledgement of the [deceased donor] patient. (P23)

Several participants reported that the *intraoperative support* received by the donor coordinator also assisted participants with not only their clinical roles but often provided emotional support during the nurses participation in these procedures: “They were great the coordinators you know they are always helpful” (P8); “I think the organ donor coordinators on both times I had participated, they had played a big part in that [helping everyone]. I think that they do an awesome job” (P18). Donor coordinators were therefore helpful as they alleviated perioperative nurses concerns of ensuring how organs were to be bagged and dispatched to receiving hospitals: “I find them [the donor coordinators] very good, they are very helpful you know they know exactly how to bag everything and label everything and all that stuff” (P4); “They were very helpful ... they would organise the transport ... such as [this] one [an organ] is going here and this one [an organ] is going there *[example of a location]” (P11); “They [organ donor coordinators] were just amazing you know and very reassuring and they were just great when there were issues” (P13).

Participants reported utilising the organ donor coordinator as a resource person when they stumbled across some hurdles in which they required guidance or additional general information: “The *[Donor Coordinator] lady, she really took me under her wing. She was great to me she was really good, and supportive” (P5); “They were very helpful and informative on all angles and all degrees and they were willing and prepared to answer any questions that we had” (P11). Whilst another participant commented:

I like the fact that the person *[Organ Donor coordinator from the Donation Agency] was always present, every single time [a procurement took place] they would be there, and they would always, if you didn’t have information they would give you the information. That was good and they are almost like a champion in the theatre, the *[Name of Donation Agency] people they’re the people who keep things going [coordinating the procurement process] and they seem to do that really well. (P6)

Several participants explained that without the presence of the organ donor coordinator they would find procurement surgical procedures difficult: “Absolutely, you know if they [organ procurement coordinators] weren’t there [in theatre] it would be a really difficult process I think” (P16); “The organ [donor coordinator] retrieval lady who came she was there quite quickly to do the heart and lungs. I don’t know how we would have coped without her” (P18). Most importantly, organ donor coordinators also were reported to assist perioperative nurses intraoperatively to quickly come to terms with a donor’s death by explaining the donor’s brain stem test results:

They are organising the aspects that they are involved in but ... it’s the support that they offer and their explanation of the process of what’s happened up to [each] point of surgery and they’ll always explain to you and show you the brain stem testing that’s occurred prior to consent being obtained [from family], they showed you this to actually identify that the patient has actually died and that brain stem death [has occurred] ... that’s always really reassuring. (P15)

Having the *intraoperative support* of the organ donor coordinators made participants feel a little more relaxed as they often advocated these surgical procedures and assured perioperative nurses about the benefits of procurement surgery to recipient patients. This support assisted nurses to better understand the positive aspects of the procurement procedure. Several participants found that in attempting to find meaning they would ask organ donor coordinators how they themselves come to terms with their roles:

I think they are bloody marvellous actually I do. I have spoken to them [organ donor coordinators] about their involvement in the whole thing and [asked them] how do they deal with it [the donor's death and the procurement surgical procedure] and they see it as a positive, you see. (P4)

Other surgical team members such as procurement surgeons were also reported to provide *intraoperative support* to perioperative nurses. Surgeons also supported perioperative nurses by alleviating any of their fears about the procurement surgical process. Surgeons often described the positive aspects of procurement surgery and provided assurances to perioperative nurses during the procurement surgical process: "They [procurement surgeons] always spoke so positively about organ donation and the need for organs" (P4). This was further emphasised by another participant:

The surgeons all ... I think the surgeons approach was lovely ... They were able to explain the positive outcomes [of the procurement procedure to recipient patients] and you know that they were able to assure you at any time if you did want to say "Look I'm not too sure about this or whatever" they were quick to step up and say look you know be assured about this and that you had that comfort zone there. (P8)

Having these assurances assisted some of the participants to accept their roles in procurement surgery: "If I had to ask any questions they [procurement surgeons] would have actually educated me and gone through it with me" (P12). Procurement surgeons were also aware that perioperative nurses did not always undertake these procedures on a regular basis therefore they were accommodating towards nurses during the surgical procedure: "The surgeons were also willing to answer any questions ... well they were even quite happy to actually show you, explain [things] as they were [operating] going through what they were doing" (P11). Therefore they were reported as not only understanding but tolerant of nurses who may not have had extensive experience in procurement surgical procedures: "They've [procurement surgeons] obviously had to go to do retrievals elsewhere so they are fairly tolerant as to [nervous laugh] the *[Name of Hospital] guys are very tolerant of [helping other staff] so they were good at providing support" (P19).

6.5.2 Teamwork united as one

Teamwork united as one was identified as the second component of *levels of support* which was reported as a condition influencing the participants' ability in *finding meaning* when participating in a procurement surgical procedure. As DiPalma (2004) explains "teamwork requires a shared understanding of the rules and considerations that move beyond

individual perspectives toward the larger picture” (p. 300). Moreover, Lingard, Garwood and Poenaru (2004) assert that “the health care team’s performance is influenced by social relationships and communication patterns” (p. 691).

Therefore, within the context of the current study participants acknowledged that teamwork was a vital precursor in their ability to function as a surgical team and viewing procurement procedures as a positive surgical experience. Therefore, surgical team members were respectful of the difficult nature of procurement surgical procedures: “There is a knowing that it’s not a nice situation [the procurement surgical procedure] so ... you’ve obviously pleasant to each other even when in such stressful situations such as retrieval procedures” (P18).

Teamwork also encompassed providing an appropriate and a respectful approach to care for donor patients. Participants who worked as part of teams who ensured that this occurred viewed these surgical procedures more positively. It was therefore important for participants to work in teams which valued this aspect. One participant emphasised the importance of this claiming that if this did not occur she would get very cross and find her participation difficult:

It [the procurement surgical procedures] was very much business as usual there was still quite an element of seriousness to it because it was obviously, it’s someone’s life [long pause] and I’m quite, I think it’s fair to say actually that when a person dies under any circumstances I get quite cross if people [within the surgical team] laugh and joke around them [the donor] particularly when we are laying them out. I take that role very seriously ... I’m a person that doesn’t normally get cross but that’s a time I would get very cross if people in the team if they took it lightly ... I would find it difficult if that took place. (P10)

This aspect was verified by another participant:

I found that within the theatre everybody was very professional and they always were in those theatres, people aren’t joking around as much. It does have a more, this is a serious side of life ... life and death so let’s do our job and just be very professional about it. (P6)

Moreover, participants explained that for the surgical teams to function successfully each team member was required to be technically competent, goal oriented, communicate effectively and be adaptive to the changing situations of the surgical procedure. When participant’s experienced a positive *teamwork united as one* experience this assisted them to overcome the problem of *hiding behind a mask* and *finding meaning* from their experiences.

Participants reported that *teamwork united as one* took place for the majority of procurement surgical procedures. Several of the study participants identified that they had had positive experiences with working alongside procurement surgical teams. They experienced teamwork dynamics which encompassed working collaboratively to not only

ensure that the outcomes for the donors organs were procured successfully, the donor was cared for in a respectful manner but also ensured that each and every surgical team member feels valued and supported as part of their role. Working collaboratively with procurement surgical teams at the time of their participation reinforced participant's positive experiences: "You know there was a real sense of co-operation and you got the feeling that you were doing something that was a positive thing" (P8).

When surgical teams worked together; *teamwork united as one*, it made participants feel more comfortable emotionally, physically and professionally: "Everybody [the procurement surgical team] always behaved appropriately, spoke appropriately, and managed events appropriately ... and everyone supported each other" (P6). There was a sense of "teamwork" and co-operation between procurement teams and the nursing staff working together: "They were good [the procurement surgical teams] ... they got in and they did their job as best as possible" (P20); "It was very positive, it was a really positive experience ... as the nursing team, the procurement teams, staff wise [they were] all fantastic ... everybody worked well together" (P5).

Although participants had not worked previously with procurement teams they reported that they were still able to work effectively and efficiently as a result of *teamwork united as one* which encompassed working together towards one unified goal: "There was team work. I must admit the general surgeons and the cardiac surgeons worked very well together and the organ donor coordinators. The whole team worked well ... and that was really good ... we were all there for the same purpose" (P19). Another participant explained that the approach of teamwork made her experiences more positive when participating:

The surgical team actually I think they make it [the experience] so much better ... we had a wonderful surgical team and the different [procurement] teams who came in to procure the heart ... they were also lovely as well and very patient and that kind of thing helps. (P14)

This experience was similarly validated by another participant:

Well the anaesthetist, that was whoever you know, was on call for the day ... the procurement surgeons were always very matter of fact about what they do, they knew what they were doing and they got on and did it. The nursing staff that were participating in the cases with me all knew what they were doing also so we had a camaraderie you know, let's get on and do it. (P8)

Moreover as participants were not continually working with the same procurement surgical teams they were able to become more efficient with anticipating their needs as result of experiencing an environment which promoted teamwork: "I think with procurement procedure working with a good surgical team you also maybe ... get more efficient as well with what they are doing and what they require" (P18). Working cooperatively as part of the procurement surgical team, organ donor coordinators also fostered a teamwork approach ensuring that all aspects of the procurement process were executed as smoothly

as possible: “I think the fact that the donor co-ordinators are so experienced and they certainly make the whole process much smoother for the nursing staff” (P15). When this occurred participants were able to feel more comfortable about their work roles as they experienced decreased anxiety and stress throughout the procurement process.

Participants also reported that they worked well with procurement surgical teams while working within time constraints. As a result of teamwork which encompassed team morale they were able to meet these deadlines:

Good team morale, you know that often helps us ... “Oh come on we’ve got 15 minutes left” or whatever “We’ve got to get this one on the plane and the police are all outside waiting to whip up to the airport.” So you know that can sort of give you a little bit of a focus if you like to get a move on. (P4)

Other participants experienced *teamwork united as one* when procurement surgeons showed understanding and displayed patience towards perioperative nurses’ limited knowledge about the procurement process. One participant touched on this aspect and highlighted that in her experience a procurement surgeons caring approach towards her lack of knowledge amongst the surgical team members exemplified the teamwork spirit which she found meaningful:

There have been times when I have been in other [surgical] procedures where they’ve [surgeons] been very impatient you know they’ve not tried to support one another or a person who’s obviously not familiar with what is going on. I’ve been in other situations where that is the case but ... specifically in retrieval or procurement of organs I’ve never struck it. There was one particular surgeon who was patient and understanding with me ... I felt part of the team and respected for my role regardless of my level of knowledge. This was important during such a difficult procedure. I mean, in other surgical procedures ... in fact they are quite rude [surgeons] and they can tell you to go outside or they will actually say “Get me somebody else,” ... “because this one doesn’t know what they are doing” and they are quite rude and in that instance they haven’t been supportive. (P20)

Participants who had more positive teamwork experiences felt encouraged to continue to participate in further procurement surgical procedures as they felt supported and part of the team that was making a difference in the organ donation process. Several participants therefore felt valued for their input and roles as part of the team and as a result felt reassured and better able to cope with their experiences: “Just the good operating team that ... I basically worked with ... they make you feel like part of the team ... so you want to continue to be involved” (P12). This sentiment was also expressed by another participant:

They are good, mostly I work with *[Surgeons Name] I think he is the main one who is the procurement surgeon for organs in our *[Name of Hospital] at the moment and he was good, he is a nice surgeon to work for and is very understanding. (P16)

Effective and open communications during the procurement surgical procedures was also reported to unify the procurement surgical team. Good communication was reported as assisting participants to feel less anxious when participating as part of the surgical team: “When procurement teams communicated clearly and nicely ... I felt less anxious” (P35). Open communication ensured that participants understood what they were doing throughout the procurement surgical process and knowing that they could ask their fellow colleagues if they were uncertain. Participants who experienced teamwork with open communication were better prepared for the procurement procedure and were more accepting of their roles and hence were better able to find meaning from their experiences. As exemplified by one participant effective communication aided her to better accept her part in the procedure:

Communication, that’s the biggest thing that has helped me in my role, people communicating things to me, telling us what was happening and how long it was going to be and telling us about the [donor] patient actually telling us what happened to the patient. We needed to know that, well I did ... I could better accept what we were doing. (P10)

Several participants articulated that increased and open lines of communication amongst the surgical team members ensured that they were better prepared for surgery. Several participants reflected that the organ donor coordinators were the predominant person to initiate this communication and hence promote the *teamwork united as one* work ethic:

I felt that the donor co-ordinator tried to communicate as effectively as possible because it was, that type of procedure that doesn’t happen that often and the majority of staff that were on that day had perhaps only ever seen that kind of procedure [a procurement procedure] happen on one or two occasions before but by communicating they tried to offer their support and to the staff that were there at the time. I felt that more of that was actually communicated by the [organ] donor co-ordinator. I felt that they were very good at communicating with the nursing staff and letting them know what organs had been consented to be retrieved and also ... generally what would happen [during the procedure] and what would happen with the packaging and the dispatch of organs. (P15)

In summary, *levels of support* was conceptualised as the second positive condition influencing the participant’s experiences of *finding meaning*. *Levels of support* encompassed two components; *intraoperative support* and *teamwork united as one*. These components were believed to positively influence the participant’s experiences of *finding meaning* when taking part in procurement surgical procedures. Participants articulated that when *intraoperative support* occurred they experienced lower levels of stress and anxiety and were better able to cope and come to terms with their involvement with each procurement experience. In addition, when participants worked collaboratively with surgical teams this unified the surgical team members working towards one goal and one purpose. This sense of *teamwork united as one* influenced participants in *finding meaning* from their professional roles as they were further able to find meaning towards their own

participation in these procedures. This further provided an opportunity for nurses to come out from *hiding behind a mask*.

6.6 Summary

This chapter presented the conditions influencing the perioperative nurses experience of the basic social psychological process of *finding meaning* when participating in multi-organ procurement surgical procedures. Three conditions influenced the perioperative nurses' experience of the process of *finding meaning* these were: *work conditions*; *levels of knowledge and experience* and *levels of support*. *Work conditions* was the first influencing condition and participants articulated that as a result of *a change in work culture* and *better work conditions* they were better prepared to cope with the demands of procurement surgical procedures. The second condition influencing the basic social psychological process of *finding meaning* was identified as participant's *levels of knowledge and experience*. Participants' reported that *having prior knowledge and experience* influenced their ability to feel more prepared to cope with not only the technical but the emotional demands of the procedure. Participants also engaged in *sharing knowledge through team mentoring*. The third and final, condition influencing the study participants' experience of *finding meaning* was identified as *levels of support*. Participants described that when they received increased *intraoperative support* from surgical team members that they found this helpful in *coming to terms* with their professional roles as this reduced their levels of stress and anxiety. Participants also identified *teamwork united as one* as working collaboratively with surgical teams who expressed mutual respect and understanding for each surgical team member's role as further assisting them in *finding meaning* in a positive fashion.

CHAPTER 7

Discussion

"It is true that transplant surgeons saved patients, but the patients rescued us in turn and gave meaning to what we did, or tried to" (Starzl, 1992, pp. 338-339)

7.1 Introduction

In this chapter a comprehensive overview of the substantive theory of *finding meaning to overcome hiding behind a mask* is presented. The final objective of this grounded theory study is to further place the substantive theory within the context of relevant scientific literature and related theories. Throughout the previous chapters pertinent literature on the subject area has been woven into the research findings to illustrate the relevance of the newly developed theory. As an extension of this, a presentation of relevant existing theories is presented in this chapter with comparisons to the findings of the developed theory in order to further position the substantive theory. Five theories were identified which encapsulated various aspects and components of the newly developed substantive theory. These theories were identified as; "Human Caring Theory" (Watson, 1988); "Human Becoming Theory" (Parse, 1981); "Death and Dying" (Kubler-Ross, 1969); "Stress and Coping" (Lazarus & Folkman, 1984) and "Awareness of Dying" (Glaser & Strauss, 1965). In addition, a comparison of relevant research studies related to procurement surgery within the substantive area is also presented to further position the theory.

7.2 The substantive theory of *finding meaning to overcome hiding behind a mask*

The substantive theory of *finding meaning to overcome hiding behind a mask* was developed using the grounded theory method. A significant feature of the developed substantive theory was that the findings were supported by the data and articulated by the participants' as a shared concern. This shared concern was articulated as the basic social psychological problem of *hiding behind a mask* and the problem was addressed through the participants' engagement in the basic social psychological process of *finding meaning*. Participants' movement through the stages of the basic social psychological problem and the basic social psychological process were also affected by the conditions influencing their experiences. The substantive theory of *finding meaning to overcome hiding behind a mask* is presented schematically in Figure 7.1.

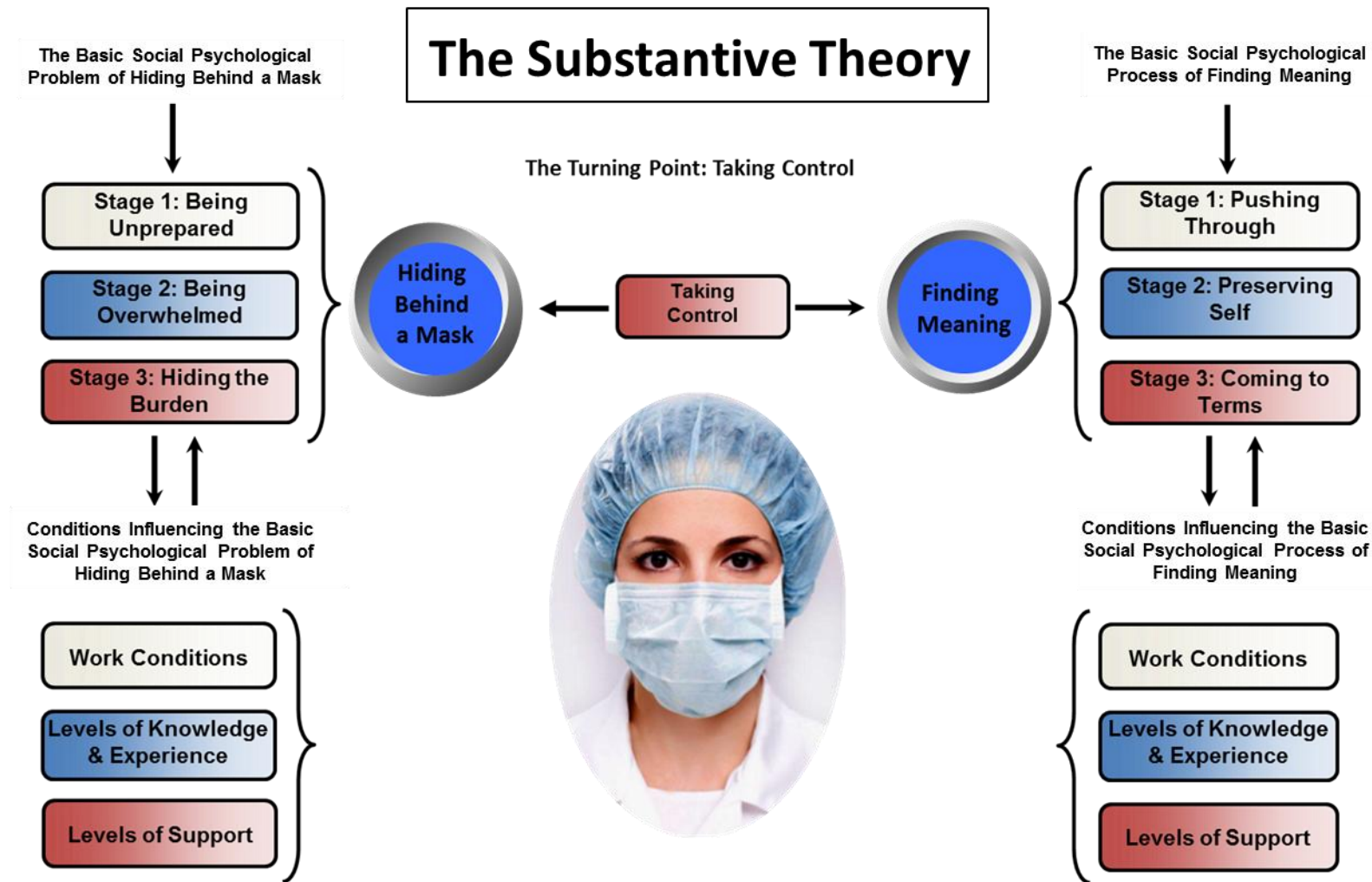


Figure 7.1: The substantive theory of finding meaning to overcome hiding behind a mask

The basic social psychological problem experienced by the participants of this study was articulated as *hiding behind a mask* when participants were initiating care for donors undergoing multi-organ procurement surgical procedures. The problem of *hiding behind a mask* was comprised of three stages: *being unprepared*; *being overwhelmed* and *hiding the burden*.

Participants articulated hiding throughout all three stages of the basic social psychological problem. In the first stage, participants reported *being unprepared* when *confronted to participate* in the procurement surgical procedure as they lacked knowledge and experience often *not knowing what to expect* of the procedure or their professional role. Several participants were unprepared for *being exposed to death* and the occurrence of death in the operating room environment and found it difficult assisting with *operating on a cadaver donor* and dealing with *the grieving family* which encompassed *witnessing family grief* and on occasions *stepping into the family's role by default*.

The second stage, of the basic social psychological problem of *hiding behind a mask* was reported as *being overwhelmed*. This stage saw participants *being overwhelmed* with *fears of facilitating the death* of the donor and of having doubts about whether the donor was really deceased as a result of lacking understanding of brain death testing or the DCD process. Participants also felt overwhelmed at *the graphic nature of what was being witnessed* during the procurement surgical procedure and experienced *role conflict towards the procurement procedure* as a result of their participation. In addition, they were overwhelmed by their *emotional responses and experiences* when participating in these procedures. For some participants these experiences included experiencing *nightmares and flashbacks*.

Participants moved through the third and final stage of the basic social psychological problem of *hiding behind a mask*, which was described as *hiding the burden* where they were *suppressing personal beliefs and attitudes* and *hiding an objection to participate* in these procedures. As a result of having to care for deceased donors several of the participants were confronted with their own thoughts of *death and spiritual 'afterlife' beliefs* which challenged their views of ensuring they were providing appropriate levels of post mortem and spiritual care within the operating room environment. Moreover, the participants were *hiding the burden of not being able to cope* whilst *hiding behind a mask*.

Conditions influencing the basic social psychological problem of *hiding behind a mask* encompassed: *work conditions*; *levels of knowledge and experience* and *levels of support*. *Work conditions*, identified as the first influencing condition encompassed the participants socially isolating work environment as a result of *working behind closed doors and the culture of the operating room* which predisposed participants to resort to the behaviour of *hiding behind a mask*. Nurses also reported non disclosure about the procurement procedure and reported experiencing increased stress and anxiety whilst waiting for a procurement surgery to commence. The second influencing condition, labelled as *levels of knowledge and experience*, was recognised as influencing the participant's ability to be prepared and cope with procurement procedures. Participants articulated that they were

lacking professional development opportunities and education resources as well as *limited mentoring opportunities* to gain further experience in procurement surgery. The third and last condition influencing the study participants' experience of *hiding behind a mask* was identified as *levels of support*. Participants described that they were *lacking organisational support, surgical team support* from their peers, and *access to external professional support* at the time to manage their participation experiences following these surgical procedures.

In an attempt to overcome the problem of *hiding behind a mask*, the data revealed that participants engaged in the process of reaching a turning point which was labelled as *taking control* before they could move into the basic social psychological process of *finding meaning*. For several participants reaching the turning point of *taking control* was an internal process and necessary step in modifying their perceptions, attitudes and behaviour. In reality as participants had to participate in procurement surgical procedures they were forced to reach the turning point of *taking control* which occurred prior to reaching the first stage of the basic social psychological process identified as *pushing through*. Further, the turning point of *taking control* was described by participants as taking control of their own internal turmoil and rationalising the situation they were placed in when participating in a procurement surgical procedure.

The basic social psychological process of *finding meaning* was used by the participants to resolve the problem of *hiding behind a mask* when participating in procurement surgical procedures. The process of *finding meaning* comprised of three stages: *pushing through; preserving self* and *coming to terms*. Participants articulated focusing on *pushing through* their work roles by focusing on *getting the job done* whilst primarily *focusing on the surgical procedure*. Several participants also emphasised the need to focus on *being accountable for their practice* and *advocating for the donor* during this stage. Participants spoke of dissociating from their experiences by *suppressing hidden thoughts and feelings and being accountable for their practice*. Moving into the second stage labelled as *preserving self*, participants focused on *being resilient* and *relying on established coping mechanisms*. They took the time to focus on their own personal needs labelled as *nurse self care* by *paying their last respects* to the donor and releasing *their pent up emotions*, leaving their work issues at work and undertaking other *self care activities*. In *preserving self*, participants sought support from various sources such as; *seeking support from their peers; support from external nursing colleagues; seeking support from family and friends; seeking pastoral care* and lastly *seeking professional support*.

The third stage, identified as *coming to terms* dealt with *participants placing their participation role into perspective* by *coming to terms with mortality and the donors' death*. *Coming to terms* also occurred when participants engaged in *honouring the donation wish* and further *honouring the donors' decision to be an organ donor*. Several participants were able to come to terms with the donor's loss by *honouring the family's wish to keep the memory of their loved one alive* by partaking in activities such as cutting lockets of hair, taking hand and foot prints as keepsakes. Participants also engaged in the process of *assisting in preserving life for the greater good* by focusing on their professional roles and the contributions they made to the organ procurement process. For several participants

this was achieved by *focusing on organ viability for recipients and thoughts towards recipient patients* in need of such organs.

Conditions influencing the basic social psychological process of *finding meaning* encompassed: *work conditions; levels of knowledge and experience* and *levels of support*. *Work conditions* were identified as the first of the influencing conditions and were significant in that participants articulated that as a result of *a change in work culture* and *better work conditions* they were better prepared to cope with the demands of procurement surgery. Participant's *levels of knowledge and experience* were identified as the second influencing condition. They reported that *having prior knowledge and experience* influenced their ability to feel more prepared to cope with both the technical and emotional demands of the procedure. Participants also engaged in *sharing knowledge through team mentoring*. *Levels of support* were identified as the third and last condition influencing the study participants' experience of *finding meaning*. They described that when they received increased *intraoperative support* from their fellow surgical team members they found this support helpful in *coming to terms* with their professional roles as this reduced their levels of stress and anxiety. Similarly, participants articulated working collaboratively with surgical teams who expressed mutual respect and understanding for each surgical team member's role which was labelled as *teamwork united as one*. *Teamwork united as one* influenced participant's ability in *finding meaning* in their participation as they were working towards the same goal and purpose.

In summary, the substantive theory saw participants move from a state of *hiding behind a mask* their experiences of *being unprepared, being overwhelmed* and *hiding the burden* to reaching a turning point of *taking control* and moving into the process of *finding meaning* by *pushing through, preserving self* and *coming to terms*. Three conditions were identified as influencing the participant's experiences of *hiding behind a mask* and *finding meaning* these were identified as *work conditions, levels of knowledge and experience* and *levels of support*.

7.3 Comparison of the substantive theory of *finding meaning* to overcome *hiding behind a mask* with other theories

The following section details similarities between the substantive theory of *finding meaning* to overcome *hiding behind a mask* and other relevant theories. A comprehensive literature search was conducted when the developed theory emerged during data analysis yet no substantive theories related to perioperative nurse's experiences of participating in multi-organ procurement surgery were found. However, several theories were identified within the literature which reflected important components and similarities to elements of the developed substantive theory. The theories presented here encompass: "Human Caring Theory" (Watson, 1988); "Human Becoming Theory" (Parse, 1981); "Death and Dying" (Kubler – Ross, 1969); "Stress and Coping" (Lazarus & Folkman, 1984) and "Awareness of Dying" (Glaser & Strauss, 1965).

7.3.1 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Watson's (1988) "Human Caring Theory"

Jean Watson's (1988a, 1988b) caring theory offers a framework that influences an understanding of health, illness, quality of life, death and the human experience by embracing and intersecting her theory with art, science, humanities, spirituality, and new dimensions of mind body spirit medicine. Three major elements are described within Watson's caring theory. These include; the carative factors, the transpersonal caring relationship and the caring occasion/caring moment. Through her work, Watson (1988b) emphasised that "It is my hope that it will also guide others to join me in my quest to elucidate the human care process in nursing, preserve the concept of the person in our science, and better our contribution to society" (Watson, 1988b, p. ix). The aim of further work was to illuminate "a model of caring and healing practices that take medicine, nursing, and the public beyond traditional Western medicine, beyond the 'cure at all costs' approach" (Watson, 1999, p. xiii). The caring theory therefore also encompasses the interconnectness of relationships between humankind, technology, nature and the universe (Watson, 1999). As stated by Watson (1999) "it offers a search for the spiritual aspects of our being and our approaches to health and healing" (Watson, 1999, p. xiv).

Watson's original ten carative factors can be directly applied by any nurse in a clinical setting to better meet the emotional, spiritual and physical need of patients in their care (Watson, 1997). Watson (1997) described her ten carative factors as being "embedded in a philosophy and value system which was humanitarian, aesthetic, and spiritual, attempting to honour the human dimensions of nursing work and the inner life world and subjective experiences of the people [nurses] serve" (p. 50). The ten carative factors were further developed to "clinical caritas" and used as a model of transpersonal caring (Neil, 2002). Transpersonal caring is demonstrated in an event or actual caring occasion where the nurse seeks to connect with, embrace the spirit or soul of the patient, through the processes of caring and healing (Watson 2001). As stated by Watson (1996):

The nurse attempts to enter into and stay within the other's frame of reference for connecting with the inner life world of meaning and spirit of the other; together they join in a mutual search for meaning and wholeness of being and becoming to potentiate comfort measures, pain control, a sense of well-being, wholeness, or even spiritual transcendence of suffering. The person is viewed as whole and complete, regardless of illness or disease. (p. 153)

Moreover Watson (2001) asserts that the nurse must have an inner peace with her own mortality as "opening and attending to spiritual-mysterious and existential dimensions of one's own life death; soul care for self and the one-being-cared-for" (Watson, 2001, p. 347). The nurse must therefore be comfortable with death and dying and possess a deep understanding and acceptance of all life cycles and be prepared for their own death (Watson 2002). Caring is directed to a pain free death with dignity and a belief of a spiritual transformation or journey after death.

Within the context of this study, from a broad perspective the work of Watson's (1988b) caring theory reflected important components of caring that were central to the substantive theory of *finding meaning* to overcome *hiding behind a mask*. Participant's experiences of working in procurement surgery and caring for deceased brain dead and DCD patients elevated their understanding and acceptance of the life cycles. During the caring occasion/caring moment participants made attempts at *finding meaning* by trying to understand from the donor's perspective the unique decision to be an organ donor. Participants attended to the donor's spiritual and soul care during the post-mortem care with a connectedness to the donor patient at a spiritual level. Participants spoke of reaching out to the patient by saying a secret thankyou ritual and forming a deeper connection at a spiritual level. In caring for donor patients, participants ensured that donors were treated with dignity and respect, ensuring that they were not just an object but a human being and treated as a whole regardless of their death status.

During the process of caring for the donor, participants were also able to engage in the process of *preserving self* by gaining understanding in the human experience from the perspective of the donor wishing to donate their organs and the needs of their family's ensuring that their loved ones wishes were met. This precipitated, participants *finding meaning* not only through the death of the donor, their wishes to donate their organs but emphasised strongly the importance of their own participation in these surgical procedures so as they could further honour the decisions made by these donor patients.

A comparison of the current study's substantive findings with components of Watson's (1988) "human caring theory" revealed several similarities. Participants within this study exhibited several aspects of Watson's (1988) "carative factors" in relation to caring for donors and meeting their spiritual and physical care needs during and after a procurement surgical procedure and illustrated these throughout the substantive theory of *finding meaning* to overcome *hiding behind a mask*. The substantive theory further builds on Watson's (1988) caring theory by broadening the scope of knowledge on how perioperative nurses provide care for organ donors within the context of multi-organ procurement surgery. In addition, the substantive theory also emphasises the unique caring role provided by perioperative nurses towards organ donors, both brain dead and DCD donors and the constraints in providing this care within an operating room context which has not been described previously within the literature.

7.3.2 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Parse's (1981) "Human Becoming Theory"

Parse's (1981) original "Man-living-health" theory was first published in 1981 and was renamed "the human becoming theory" in 1992 (Parse, 1997; Parse, 2011). Parse (1996) asserts that the human becoming theory "is a human science theory created in 1981 as an alternative to traditional nursing" (p. 56). According to Mitchell (2002) "Parse supports the notion that nurses require a unique knowledge base that informs their practice and research and this knowledge (of the human-universe-health process) is essential for nurses to fulfil their commitment to mankind" (p. 528). Her theory was developed as a human

science nursing theory with three principles: structuring meaning multidimensionality, cocreating rhythmical patterns and cotranscending (Parse, 1981, 1998). The first principle of structuring meaning multidimensionality as proposed by Parse (1998) is described as “the ongoing constructing of reality through assigning significance to experiences at many realms of the universe that are lived all-at-once”(p. 35). The principle of structuring meaning multidimensionality encompasses three concepts: imaging, valuing and languaging. Imaging is the individual’s view of finding meaning after having found answers to questions in light of a reality and their view of things (Parse, 1998). Valuing was described as the second concept of structuring meaning and is described by Parse (1998) as the “confirming-not confirming of cherished beliefs in light of a personal worldview” (p. 38). Parse (1998) affirms that people continue to make choices about how they act, think and feel and can reassess and change their choice at any given time which thereby changes their thinking and direction in life (Parse, 1998). Languaging was described as the third concept of structuring meaning multidimensionality. Parse (1981) further emphasises this concept by explaining that:

Languaging is not just the content of what a person says with words, but how the whole message is uncovered in the context of the situation. It is the rhythmical moments of silence, the choice of words and syntax, the intonation, the facial expressions, the gestures, the posture, and that which is not said that constitute the symbolic expression which is characteristic of languaging as a concept of structuring meaning multidimensionally. (p. 48).

In this study, participants displayed similar examples to those defined in Parse’s theory and the first principle of structuring meaning multidimensionality. Participants spoke of examples of imaging such as finding their own answers to questions on the procurement surgical procedure or trying to understand why they thought a certain way about procurement if they did not agree with the process. For several participants in the current study, valuing was also undertaken when participants confirmed holding their own personal views on procurement surgery and organ donation. These views although hidden from others were also seen to change after experiencing consecutive procedures. Participants explained that although their participation was viewed as difficult on an emotional level they were able to reassess their views and thinking and hence *finding meaning*. Similarly, participants also displayed various aspects of Parse’s third concept of languaging by concealing and remaining silent when they were *hiding behind a mask* and further *hiding the burden*.

The second principle, cocreating rhythmical patterns in Parse’s human becoming theory (1981) was described as “cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating” (p. 42). The principle of cocreating rhythmical patterns encompasses three concepts: revealing-concealing, enabling-limiting, connecting-separating. Parse (1998) referred to the first concept of “revealing-concealing is disclosing-not disclosing all-at-once” (p. 43). This concept deals with how people choose to give and withhold messages about what they are thinking, what they know and who they are (Parse, 1998). Parse (1998) asserts that people also reveal-conceal differently in different situations and with different people explaining

that “there is always more to a person than what the other experiences in the immediate situation; there is always that which is all-at-once concealed” (p. 44).

The second concept of enabling-limiting represents the fact that with each choice there are opportunities and restrictions and living with the consequences of choices. Mitchell (2002) provides an example of this when a family makes a statement such as “this is the worst thing that could have happened to our family, but it has helped us in many ways” (p. 532). The third concept of connecting-separating Parse (1981) explains as “man is connecting with one phenomenon and simultaneously separating from others” (p. 54). Parse (1998) further added that this concept represents how people are “with and apart from others, ideas, objects and situations all-at-once (p. 45).

The concept of revealing-concealing was particularly relevant in this study, where participants displayed elements similar to those described in Parse’s theory such as when *hiding behind a mask* they chose to conceal the reality of their experiences in procurement surgery and they also chose to conceal their lack of knowledge amongst external procurement surgical teams. Participants witnessed the concept of enabling – limiting when they thought of the process of family’s having to make the decision of donating their loved one’s organs. On a personal level participants also experienced the concept of connecting-separating from the people (the donor’s) and projects (the procurement surgical procedure). Some participants throughout the stage of *pushing through* used their work as a defensive barrier by preoccupying themselves with their work duties and professional roles. During the stage of *preserving self* participants did this by depersonalising from the surgical event and not getting attached to donor patients. Some participants choose to distance themselves from the donor and their circumstances whilst others chose to not view the faces of donors, as identified through the stages of *pushing through* the surgical procedure and *preserving self*.

The third principle in Parse’s human becoming theory (1981) is referred to as cotranscending. According to Parse (1998) the principle of cotranscending in “human becoming is moving beyond with intended hopes and dreams while pushing-resisting in creating new ways of viewing the familiar and unfamiliar” (p. 46). The principle of cotranscending encompasses three concepts: powering, originating and transforming. The first concept of cotranscending referred to as powering gives meaning to life and struggles and the will to go on despite threats or hardship (Parse, 1981; Mitchell, 2002). Parse (1981) asserts “powering is a process of man-environment energy interchange, recognized in the continuous affirming of self in light of the possibility of non-being” (p. 57). Powering has been described as the force exerted in pushing to act and live whilst living with loss or the threat of nonbeing (Mitchell, 2002). Parse (1981) explains that the risk of losing self to non-being “refers to not only to dying but to the risk of losing one’s self through being rejected, threatened, or not recognized in a manner consistent with expectations” (p. 57).

The second concept of originating is about human uniqueness which holds two paradoxes: conforming-not conforming and certainty-uncertainty. Parse (1981) explains that originating is “choosing a particular way of self-emergence through inventing unique ways

of living” (p. 60). Therefore in conforming-not conforming people strive to either be like others or to be unique. Whereas, with choosing certainty-uncertainty people do not know whether it is better to be like others or better to be different (Parse, 1998). The third concept, transforming refers to change and shifting views that people have about their lives. Parse (1981) therefore refers to transforming as “deliberately choosing a new worldview and, in so doing, a new way of being” which is “self-initiated and creative” (p. 65). Parse (1988) also refers to transforming as a personal self initiated and creative undertaking which “when one has chosen a shift to a new insight, one cannot return to viewing the situation in the old way but can only move with other possibilities” (p. 53).

Within the current study participants exhibited similar examples of Parse’s (1981) theory, in particular the third principle of transcending. Participants were “powering” through their experiences of participating in multi-organ procurement surgical procedures and *coming to terms* with the experiences of caring for deceased organ donors. Participants also exhibited signs of Parse’s (1998) concept of conforming-not conforming when they chose to hide their views on procurement, organ donation and why they held a consciousness objection. Moreover, participants also showed signs of transforming and exhibiting a shift in their personal views when they were able to move through the process of *finding meaning* and in particular the stage of *coming to terms*. Like Parse’s theory (1998), the findings of the current study and the developed substantive theory of *finding meaning* to overcome *hiding behind a mask* contribute to new knowledge and theoretical understanding of the personal views held by perioperative nurses when they choose to focus on the quality of life both for donors within their care and recipient patients. The aspect of *finding meaning* in the context of health professionals assisting in multi-organ procurement surgery has not been documented within the current scientific literature.

7.3.3 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Kubler-Ross’s (1969) “Theory of Death and Dying”

Kubler-Ross’s seminal theory (1969) on death and dying has widely increased people’s awareness of the needs of dying people through her book entitled “*On death and dying*”. Her theory identified a process of grief which was experienced by her patients and was based on her work as a psychiatrist with terminally ill patients. Her patient’s responses to their impending death allowed her to formulate her theory. Kubler-Ross (1969) asserts that “death has always been distasteful to man and will probably always be” (p. 2). Kubler-Ross (1969) believed that people found it difficult to understand and accept death “death is never possible in regards to ourselves” (p. 2) and that “death is still a fearful, frightening happening, and the fear of death is a universal fear” (p. 4).

Kubler-Ross’s theory (1969) is included in this discussion as it bears relevance to the current substantive theory of *finding meaning* to overcome *hiding behind a mask*. In particular, Kubler-Ross’s earlier work and predictions shed light on how health professionals can further gain understanding through patient’s experiences of death. Kubler-Ross (1969) made the statement that “the more we are achieving advances in science, the more we seem to fear and deny the reality of death” (p. 6). This was evident in the current study

where there were often doubts by participants when true death had occurred. Interestingly, Kubler-Ross (1969) also made reference to organ donation by stating “science and technology will enable us to replace more vital organs, and the responsibility of questions concerning life and death, donors and recipients will increase manifoldly” (p. 15). As noted by participants in the current study, these same questions about life and death were echoed throughout the various stages of the substantive theory. Moreover, Kubler-Ross’s (1969) acknowledgement of “dying nowadays is in many ways more gruesome, more lonely, mechanical, and dehumanized; at times it is even difficult to determine technically when the moment of death has occurred” (p. 7) was also a view shared by the participants in the current study. In the current study, Kubler-Ross theory (1969) bore relevance to how participants viewed death and their reactions to dealing with deceased organ donors and the multi-organ procurement surgical procedure by *hiding behind a mask*. Participants within this study also had difficulty with conceptualising death and entered into many of the stages and reactions to death and dying from a health professional perspective as identified within Kubler-Ross’s theory.

Kubler-Ross (1969) describes five distinct stages (not always undertaken in a sequential order) through which the individual passes in coming to accept death as; denial and isolation, anger, bargaining, depression and the final stage as acceptance. Her theory articulated that patients would work through their different reactions as “coping mechanisms” used towards “this new and stressful life situation” (p. 33). Kubler-Ross (1969) refers to the first stage of her theory as denial and isolation whereby patients become aware of having a terminal illness. During this stage patients were reported to be shocked at first by the news and displayed first reactions such as denial “No, not me, it cannot be true” (p. 34). Kubler-Ross (1969) asserts that “denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time, mobilize others, less radical defenses” (p. 35).

Kubler-Ross (1969) referred to the avoidance of death as a “flight from facing death calmly” (p. 7) by the use of euphemisms such as making “the dead look as if they were asleep” (p. 6). Avoidance of death and denial was also similarly expressed by the participants in the current study. Similarly, in relation to this study dealing with death and dying also initiated personal reactions of denial by the study participants. Kubler-Ross’s (1969) first stage of “denial and isolation” also bore relevance to components in the current substantive theory of *finding meaning to overcome hiding behind a mask*. Whilst moving through the stages of *hiding behind a mask* several participants denied *being unprepared, being overwhelmed, and hiding the burden*. These stages saw participants denying the reality of their own vulnerabilities. An obvious example of denial by the participants was that when undertaking a procurement surgical procedure several participants disclosed that they denied that the patient was deceased by undertaking their roles and the surgical procedure as if the donor was any normal operative procedure. This they disclosed was a coping mechanism used to get through the surgical procedure. Several participants therefore displayed reactions of denial and disbelief upon caring for a deceased organ donor, often questioning whether they were really deceased at the time of undertaking the procurement surgical procedure. Upon participating in a procurement surgical procedure they spoke of the initial shock at

witnessing such a procedure. As a result, participants were in denial about the effects procurement surgery had on their professional roles and the impact on their well-being. Consequently, they became isolated through *hiding behind a mask*. Therefore Kubler-Ross's (1969) theory bore similarities to the current study and the use of denial by these health professionals in dealing with aspects of death and dying.

The second stage of Kubler-Ross's (1969) theory is described as "anger". The patients within her study moved into this "when the first stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy and resentment" (p. 44). As noted by Kubler-Ross (1969) "The stage of anger is very difficult to cope with from the point of view of family and staff. The reason for this is the fact that this anger is displaced in all directions and projected onto the environment at times almost at random" (p. 44).

In regards to the current study, several participants displayed reactions of anger and resentment whilst in the second stage of *hiding behind a mask* and *being overwhelmed*. Participants stated that they felt anger at the circumstances of the donor's death or if it was child for example as one participant expressed: "Why had this happened to such a young person?" (P24). Participants also reported anger at *experiencing the realisation of death* as they could no longer deny the fact that they were operating on a live patient but *operating on a cadaver donor*. In addition, participants displayed reactions of anger when *witnessing the death of the DCD donor* or when *stepping into the family's role by default* when donors had to experience death without their family beside them. When participants moved into the second stage of *hiding behind a mask* and *being overwhelmed* they also reported anger and *fears of facilitating death* of the donor when they questioned whether the donor was in fact deceased. Anger was also reported as an *emotional response* by participants as a reaction to witnessing the procurement surgical procedure and having to participate.

Several participants displayed reactions of resentment when *being unprepared* and having to deal with *increased workloads* due to the demand for these emergency surgical procedures. Resentment was also identified in the final stage of the basic social psychological problem of *hiding the burden*. Participants reported feeling resentful when *suppressing personal beliefs* and having to participate in a procurement surgical procedure. Often this occurred when they were *hiding a conscientious objection* as a result of pressures to fulfil their work roles due to lack of replacement staff.

The third stage of Kubler-Ross's theory was referred to as "bargaining". This stage saw participants secretly enter "into some sort of an agreement which may postpone the inevitable happening" (p. 72). These were referred to as bargains such as a "life dedicated to God" or a "life in the service of the church" or a promise to dedicate their body to "science" in the hope of extending their life (p. 74). Within the context of the current study, participants did not directly show evidence of bargaining however they did refer to forms of bargaining. During the first stage of *being unprepared* some participants displayed bargaining when they were *being confronted to participate* by deliberately swapping shifts or on-call duties when they were avoiding a known procurement surgical procedures or they chose to turn up late to work so as they would not have to relieve night duty staff

undertaking a procurement surgical procedure. Moreover when participants moved through the process of *finding meaning* and engaging in the first stage of *pushing through* for example by *focusing on the surgical procedure*, several participants made statements pertaining to forms of bargaining: “If I can just get through the case” (P4) or as another participant stated: “I just want this to be over and done with [the procurement surgical procedure] so I can go home ... and deal with my personal issues” (P21).

The fourth stage of Kubler-Ross’s (1969) theory was described as “depression”. During this stage the patients could no longer deny their illness exhibiting signs of “weakness” after undergoing further surgery and hospitalization. During this time patients “cannot smile it off anymore” (p. 75). As stated by Kubler-Ross (1969) “his numbness or stoicism, his anger and rage will soon be replaced with a sense of great loss” (p. 75). In reference to the current study, the fourth stage of depression was similarly exhibited by participants. Several participants spoke of feeling “drained”; “exhausted” or “numb” with some stating they felt depressed as a result of witnessing the procurement surgical procedure and the overwhelming loss of the donor’s life. Participants also exhibited signs of depression when referring to feeling drained at having to remain stoic throughout the procedure by *hiding behind a mask*, which for some ranged in length for a few hours throughout the surgical procedure or as described by several other participants a few years as they had not spoken about the loss’s of life they had encountered through their participation in procurement surgical procedures.

The fifth and final stage of Kubler-Ross’s theory was described as “acceptance”. Acceptance was referred to the patient’s acknowledgment of their “fate”, after working through expressing their previous feelings (p. 99). During this period the “struggle is over” and is “void of feelings” (Kubler-Ross, 1969, p. 100). According to Kubler-Ross (1969) “he will contemplate his coming end with a certain degree of quiet expectation” (p. 99) and “the final rest before the long journey” (p. 100).

In the current study, the final stage of Kubler-Ross’s theory bares resemblances to the substantive theory of *finding meaning* and the third stage of *coming to terms*. As a result of the participant’s experiences of procurement surgery they moved through the process of *coming to terms* with the reality of the donor’s death, rationalising the emotions they had experienced whilst *coming to terms with their professional* role in these surgical procedures. Similarly to Kubler-Ross’s this stage was also void of personal emotions as participants shifted their focus on *honouring the donors’ decision to be an organ donor and assisting in preserving life for the greater good* by focusing on recipient patients and their plight whilst awaiting organs. Like Kubler-Ross’s patients, participants in the current study took varied lengths of time in *finding meaning* through the process of *coming to terms*.

Kubler-Ross’s (1982) in another published text “*Working it Through*” further emphasised the importance and need for health professionals to attend to any unfinished business and grieve their losses:

We must come to terms with the many deaths -‘the little’ deaths we encounter every day, and the big deaths that mark important passages in our lives - that have marked the landscape of our journey, or we can never truly help another person fully. (p. 158)

A comparison of the current study’s substantive findings with components of Kubler-Ross’s (1969) theory of death and dying revealed several similarities. Participants within this study exhibited many of the reactions to death and loss although from a health professional’s perspective and illustrated these personal reactions throughout the substantive theory of *finding meaning* to overcome *hiding behind a mask*. The substantive theory of *finding meaning* to overcome *hiding behind a mask* contributes significant new knowledge to Kubler-Ross (1969) theory of death and dying by advancing nursing knowledge of how perioperative nurses’ deal with death and operate on cadaver donors within the operating room nursing environment. The substantive theory also highlights descriptively the perspectives of perioperative nurses’ within the clinical area by highlighting broader issues such as the need for further education on death and dying within the clinical practice area.

7.3.4 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Lazarus and Folkman (1984) “Theory of Stress and Coping”

Lazarus and Folkman’s theory (1984) of stress and coping provides a framework to understand how people react and cope to a wide variety of stressful challenges or threats. Lazarus and Folkman (1984) assert that stress is “an inevitable aspect of life” and that “what made the difference in human functioning was how people coped with it” (p. 21). According to Lazarus and Folkman (1984) psychological stress is “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19). Therefore their definition took into account “the relationship between the person and the environment” in addition to the “characteristics of the person on the one hand, and the nature of the environmental event on the other” (p. 21). A major feature of the substantive theory of *finding meaning* to overcome *hiding behind a mask* was how participants used their established coping mechanisms through the second stage of the process, preserving self to cope with their stressful experiences of participating in multi-organ procurement surgical in moving through the process of *finding meaning* from their experiences.

Coping was defined by Lazarus and Folkman (1984) as “the process through which the individual manages the demands of the person-environment relationship that are appraised as stressful and the emotions they generate” (p. 19). Moreover, they assert that coping is a “constantly changing cognitive and behavioural effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141).

Coping requires purposeful action by the individual aimed at dealing with the stressful encounter. The process of coping as described by Lazarus and Folkman (1984) serves two overriding functions; firstly “managing or altering the problem with the environment

causing distress referred to as (problem- focused coping)” (p. 152) and secondly “regulating the emotional response to the problem referred to as (emotional-focused coping)” (p. 153). Forms of problem– focused coping were described as “strategies for altering environmental pressures” and “developing new behavior or learning new skills” (Lazarus & Folkman, 1984, p. 152). As described by Lazarus and Folkman (1984) emotional- focused coping strategies have been referred to as “avoidance, minimization, distancing, selective attention, positive comparisons and wresting positive value from negative events” (p. 150). Lazarus and Folkman (1984) assert that both “problem and emotional focused coping influence each other throughout a stressful encounter” and “can either facilitate or impede each other” (p. 153).

In the context of the current study’s substantive findings, participants engaged in both problem-focused coping and emotional – focused coping. Lazarus and Folkman (1984) also emphasised that a way a person copes is influenced by his/her available resources. These coping resources include health and energy, existential beliefs about God, commitments, problem solving skills, social support and material resources. Interestingly, in the current study the resources described by these authors were also identified as either facilitating or inhibiting participant’s ability to cope with their experiences in procurement surgical procedures.

Lazarus and Folkman (1984) referred to health and energy as the person’s physical well-being describing “it is easier to cope when one is feeling well than when one is not” (p. 159). Several participants in the current study also emphasised this point, expressing they were not able to cope when they were overworked, lacking energy after having worked long hours assisting in procurement surgical procedures and then not having a break before undertaking another emergency procedure. Therefore when participants lacked health and energy they found it extremely difficult to cope with the demands of their participation within procurement surgical procedures and as a result were *hiding behind a mask* to conceal their lack of ability to cope.

Lazarus and Folkman (1984) referred to “existential beliefs, such as faith in God, fate, or some natural order in the universe, are general beliefs that enable people to create meaning out of life, even out of damaging experiences, and to maintain hope” (p. 77). Similarly, existential beliefs about God and the situation of dealing with donors deaths assisted participants to come to terms with the loss of life. Several participants used their belief in God and religion by *paying their last respects to organ donors*. Through the second stage of the basic social psychological process of *finding meaning*, labelled preserving *self*, participants were able cope with their participation by engaging in activities in caring for their own emotional well-being. Existential beliefs also assisted participants in *finding meaning* from their experiences in participating in procurement surgical procedures and *finding meaning* in the donor’s death and the legacy of saving the lives’ of several recipients.

Commitment was also described by Lazarus and Folkman (1984) as an important coping strategy:

Commitments express what is important to the person, what has meaning for him or her. They determine what is at stake in a specific stressful encounter. Any encounter that involves a strongly held commitment will be evaluated as meaningful to the extent that the outcome harms or threatens the commitment or facilitates its expression. Commitments also underlie the choices people make or are prepared to make to maintain valued ideals and/or to achieve desired goals. (p. 56)

In the current study, participants used their commitment towards their professional roles as a perioperative nurses when undertaking these surgical procedures. They also held a commitment towards *honouring the donation wish by honouring the donors' decision to be an organ donor* and in the process by *assisting in preserving life for the greater good*. As a result of being committed they were able to not only achieve the goal of their professional roles and the wishes of the donor, but were able to find their participation as meaningful.

Problem solving skills were referred to by Lazarus and Folkman (1984) as “the ability to search for information and analyse a situation” (p. 162). In the current study, participants articulated *hiding behind a mask* when they lacked appropriate education and preparation to assist in procurement surgical procedures. This was seen to inhibit their coping responses as their levels of stress increased through the stages of the basic social psychological problem of *hiding behind a mask* and the stages of *being unprepared, being overwhelmed and hiding the burden*. By employing a problem solving approach through the process of *finding meaning*, participants were able to better manage the stressful demands of procurement surgical procedures. Several participants articulated that a condition influencing the process of *finding meaning* was participant’s *levels of knowledge and experience*. Participants took a problem solving approach by enhancing their knowledge on organ donation either by attending an ADAPT course, seeking knowledge through a hospital policy manual or advice from a colleague when *sharing knowledge through team mentoring*.

Social support as described by Lazarus and Folkman (1984) “provides vital resources which the individual can and must draw upon to survive and flourish” and that “people gain sustenance and support from social relationships” (p. 243). In the current study, participants initially did not seek support due to fears of being stigmatised by their peers when *not being able to cope* and therefore continued *hiding behind a mask*. For other participants once the pressure and stress was too much to bear on their own, through the process of *preserving self* participants sought forms of social support to facilitate their coping which was referred to in the current study as *seeking personal support*. Seeking personal support encompassed support from their peers (not directly involved in the procurement surgical procedure), external nursing colleagues from their peers (not directly involved in the procurement surgical procedure), family and friends, pastoral care and professional support.

Lastly, Lazarus and Folkman (1984) referred to material resources as “the goods and services that money can buy” (p. 164). Within the context of the current study material resources can be compared to each organisation’s available resources such as staffing,

equipment and professional assistance provided to employees. Within the current study several participants spoke of encountering increased *workloads* as a result of working with minimal staff which placed them under extreme pressures to undertake their professional duties. Some participants from rural and regional areas also spoke of not having adequate resources such as equipment necessary to undertake procurement surgical procedures. Moreover, when participants required professional counselling services they could not always get time to be released off the theatre floor to attend such sessions when the department experienced staff shortages. Therefore, as a result of lacking material resources participants were not able to cope as well when they lacked these resources within their departments.

A comparison of the current study's substantive findings with components of Lazarus and Folkman (1984) theory of stress and coping revealed several similarities. Participants within this study exhibited many of the stress responses whilst *hiding behind a mask* and coping reactions whilst engaging in the process of *finding meaning*. Therefore these findings confirm several aspects of the substantive theory of perioperative nurses' *finding meaning* to overcome *hiding behind a mask*. The substantive theory and findings from this study both expand the current knowledge of how perioperative nurses react to their participation in procurement surgical procedures in addition to emphasising patterns of coping and strategies to resolve their concerns not yet identified and described within the current literature.

7.3.5 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Glaser and Strauss (1965) "Theory of Awareness of Dying"

Glaser and Strauss (1965) theory of awareness contexts amongst terminal patients also bore relevance to the current substantive theory of *finding meaning* to overcome *hiding behind a mask*. The theory of awareness of dying by Glaser and Strauss (1965) was developed when analysis was centred around participant observations in hospital settings where interactions between staff and patients from their viewpoint were analysed. Glaser and Strauss (1965) proposed a typology of awareness contexts which were differentiated as; closed awareness, suspected awareness, mutual pretense awareness and open awareness (p. 11).

Glaser and Strauss (1965) described closed awareness as "the physician decides to keep the patient from realising, or even seriously suspecting, what his true status is" (p. 29). Therefore knowledge of dying is hidden from the dying person. The next awareness context was described as suspicion awareness where the dying person suspects that he is dying. As stated by Glaser and Strauss (1965) "the patient does not know, but only suspects with varying degrees of certainty, that the hospital personnel believe him to be dying" (p. 47). Mutual pretense as described by Glaser and Strauss (1965) is "when patient and staff both know that the patient is dying but pretend otherwise-when both agree to act as if he were going to live then a context of mutual pretense exists" (p. 64). Lastly open awareness was described by Glaser and Strauss (1965) as "whenever both staff and patient know that he is dying, and acknowledge it in their actions, the context is one of open awareness" (p. 79).

Glaser and Strauss (1965) analysis focused on movement from one context to another such as people moved from a state of closed awareness to suspicion awareness, mutual pretense awareness and finally to open awareness. Their theory emphasised that most patients were looking for information and wanted to be aware of their dying condition. Moreover that it is the physician and nurse who decided when a patient or family member is ready for disclosure and how much everyone needs to know (Glaser & Strauss, 1965).

In the context of the current study, some aspects of Glaser and Strauss (1965) theory of awareness of dying were supported in the current findings. For example, although participants dealt with patients who were already deceased (brain dead donors) or live donors such as patients who would be (donation after cardiac death donors) they were dealing predominately with patients and colleagues through Glaser and Strauss's open awareness context. When participants were dealing with DCD donors the open awareness context was more prominent as participants reported experiencing similar reactions and care issues to the health professionals in Glaser & Strauss (1965) study when dealing with dying patients in general. The substantive theory uncovers new knowledge of how perioperative nurses dealt with DCD donors within an open awareness context which has not been identified within the context of caring for DCD donor patients having an organ procurement surgical procedure.

Several components of Glaser and Strauss (1965) theory of Awareness of dying was similarly identified in the current theory of perioperative nurses' experiences of *finding meaning* to overcome *hiding behind a mask* when caring for multi-organ donors within the operating suite environment. Like perioperative nurses, who are trained to save life's, the loss of donors lives was difficult to bear as they felt defeated at the failure of experiencing losses in the operating room environment. Therefore, perioperative nurses had great difficulty in caring for deceased organ donors where there was no life to be saved. Likewise Glaser and Strauss (1965) also explained that nurses within their study, once they reached the phase of being aware of "nothing more to do" the emphasis of care changed from recovery of the patient to providing comfort care (p. 204). This was also noted in the current study when participants reported focus shifted on providing post-mortem care to the donor within their care.

Moreover, a cognitive shift "of nothing more to do" was also expressed by several participants within the current study. Participants acknowledged that this occurred once there was an acceptance that the donor was in fact deceased and nothing more could be done to save the life of the donor, in particular DCD donors who were having futile treatment ceased prior to the actual organ donation. Their focus in the context of this study was to provide the best pre and intraoperative care, which ensured the donor, was treated with dignity, respect and was cared for in a comforting manner as if the donor was still a living patient.

Acknowledging the death of a patient was also emphasised by Glaser and Strauss (1965) in their study, who referred to this as "failure to discount" when the patient is dead. According to Glaser and Strauss (1965):

When a patient has just died, people who see the corpse rather soon thereafter tend, under certain conditions, to behave almost as if the patient were alive and aware of his imminent death. Temporarily the deceased is regarded virtually as a sentient person. For instance, nurses who have gotten deeply involved with a patient will sometimes back away from post mortem care of his body. (p. 113)

Glaser and Strauss (1965) explained “that people who are present at a death were struck by the remarkably thin line that stretches between life and death. Momentarily, the person now dead seems hardly dead because he was so recently alive” (p. 114). In the current study, participants also similarly expressed great difficulty in accepting the donor’s death within their care. They articulated the difficulties they experienced during the first stage of *being unprepared* when *being exposed to death*. For several participants *witnessing the death of DCD donors* was sudden as at one minute the donor was still considered alive and then in the next minute deceased, a concept that was difficult to conceptualise or come to terms with. In addition, participants also found it difficult acknowledging when the donor was deceased. For several participants acceptance of the donor’s death was only achieved through *experiencing the realisation of death*, for example at the conclusion of procurement surgical procedures when the donor’s body was cold and lifeless did death become a reality.

Within their study, Glaser and Strauss (1965) also explained that “some nurses cannot help feeling upset about a patient who is left alone to die, for example, when no family member is in attendance” (p. 238). Similarly, in the current study, several participants expressed a similar sentiment of feeling upset when DCD donors were left to die alone when their family’s had chosen not to be present at the time of their death during the stage of *stepping into the family’s role by default*. Glaser and Strauss (1965) also found that “It is also hard for any nurse to remain detached when the patient’s social loss value is very high” (p. 238). Within the current study, participants spoke of the difficulty in accepting the death of donors who were children or young teenagers where they reflected they believed they had so much to live for. Several participants had reflected that these donors’ lives were cut short and therefore their social loss value was very high.

Furthermore, Glaser and Strauss (1965) also reported that “nurses are likely to become upset at the long arduous struggle of some lingering patients, a struggle which in the end only makes the dying harder on everyone” (p. 239). In the current study, participants articulated *being unprepared for witnessing the death of the DCD donor* when it was a protracted event. This seemed to amplify the nurses and the surgical team’s experiences of the event. According to Glaser & Strauss (1965) nurses preferred to avoid the patient’s death: “The nurses’ composure is crucial during the entire final stage of dying, but especially at the moment of death, when the likelihood of breaking down is greatest. For this reason nurses usually prefer to avoid the death scene (p. 248). In the current study this was also reported by participants when *being exposed to death* in the first stage of *being unprepared*. They could not avoid the death scene of *witnessing the death of a DCD donor* however they avoided the situation by suppressing their emotions and the likelihood of breaking down by attempting to be composed whilst *hiding behind a mask*.

Glaser and Strauss (1965) also made reference as to how nurses coped with their work such as: “Outright avoidance and expressive avoidance are both strategies for precluding conversation as well as controlling work” (p. 240). In the current study, participants undertook similar activities. They did not talk about their experiences and how these had impacted on their well-being. Participants also used outright and expressive avoidance by *hiding behind mask*. Moreover, like Glaser and Strauss’s (1965) findings participants in the current study also engaged in strategies such as *pushing through* with a focus on *getting the job done* and engaged in *preserving self* as a way of controlling their work situations.

A comparison of the current study’s substantive findings with components of Glaser and Strauss (1965) theory of awareness of dying revealed that participants within this study exhibited many of the reactions to death and loss as experienced from a health professional’s perspective. Several examples provided by Glaser and Strauss (1965) theory were also illustrated by participant’s responses in caring for organ donors and experiencing death through an open awareness context throughout the substantive theory of *finding meaning* to overcome *hiding behind a mask*.

7.4 Comparison of the substantive theory of *finding meaning* to overcome *hiding behind a mask* with other research studies

The substantive theory of *finding meaning* to overcome *hiding behind a mask* also shared similarities with components of other research study findings. Not surprisingly this was so when research was undertaken on the experiences of perioperative nurses in procurement surgery in other countries. These studies shared many similarities between perioperative nurses experiences when assisting in procurement surgery. There is also a plethora of literature related to health professional’s experiences when dealing with dying patients or traumatic incidence and this has already been noted in describing and building the substantive theory in the proceeding chapters. Below are summaries of the three most salient of existing studies to the substantive theory.

7.4.1 Comparison of the substantive theory of *finding meaning* to overcome *hiding behind a mask* with Carter-Gentry and McCurren (2004) study “Organ procurement from the perspective of perioperative nurses”

The findings of Carter-Gentry and McCurren’s (2004) qualitative study using a phenomenological approach investigating the lived experiences of eight perioperative nurses participating in organ procurement surgical procedures in a large university hospital in the United State concur also describe similarities with the substantive theory of *finding meaning* to overcome *hiding behind a mask*. Carter-Gentry and McCurren (2004) identified three major themes within their study which they described as: 1) coping with participation in the organ procurement process; 2) challenges associated with participation in organ procurement and 3) response to participation in organ procurement and associated feelings.

Carter-Gentry and McCurren's (2004) first theme was reported as "coping with the procurement process" (p. 424). This first theme entailed three different coping phases reported as: preoperatively, intraoperatively and postoperatively (p. 425). According to Carter-Gentry and McCurren (2004) during the preoperatively coping phase participants within their study described preparing themselves for coping emotionally for their roles such as; numb one's self, stay focused on the task, view as "just another case" and exhibit curiosity about the donor (Carter-Gentry & McCurren, 2004, p. 425). In the preoperatively coping phase Carter-Gentry and McCurren (2004) reported themes such as; desensitization; detachment and "robotic" task-oriented focus (p. 425). Lastly, during the postoperatively coping phase Carter-Gentry and McCurren (2004) reported themes such as; simple practicality and reasoning, exercise, spirituality/prayer and verbalisation (p. 425).

In the current study, similar themes were also identified however throughout different stages of the substantive theory. Participants by *hiding behind a mask* also expressed *numbing* their emotions when *being overwhelmed* and in an attempt to focus on their roles in procurement surgical procedures. Similarly, pushing *through* was a major process of participants *finding meaning* from their experiences in participating in procurement surgical procedures. Whilst Carter-Gentry and McCurren (2004) referred to participants undertaking their roles in a "robotic" and "task-oriented focus" (p. 425), within the current study this was identified as an important process although articulated by participants as *getting the job done*; *focusing on the surgical procedure*; *being accountable for their practice* and *advocating for the donor*. Like participants in the study by Carter-Gentry and McCurren (2004) participants within this current study, also reported *relying on established coping* skills such as using prayer at the time of *paying their last respects* to organ donor patients. Furthermore, several participants also used exercise as a self care activity and sought support from peers and a chaplain as a form of debriefing from their participation experiences.

Carter-Gentry and McCurren's (2004) second major theme was reported as challenges associated with participation in organ procurement. This major theme encompassed: sympathy; personalisation of the event and actual interaction/exposure to family members. According to Carter-Gentry and McCurren (2004) participants expressed sympathy when "thinking of the donor family's grief" (p. 426). Moreover, participants personalised their participation when they dealt with specific donors such as young children or donors they could relate to as a result of their own personal experiences. Furthermore, Carter-Gentry and McCurren (2004) also reported the difficulty participants faced when interacting with the family members of donors as there was "a tendency to bond with donors as a parent would" (p. 426).

Within the current study, participants also found their participation in procurement surgical procedures as challenging. Participants noted similar experiences of sympathy and grief towards donors and the associated grief and loss of donors experienced by families. Although not reporting bonding with donor's families, participants within the current study conversely disclosed the discomfort and difficult situation of having to deal with *the grieving family*. Several nurses spoke of *being unprepared* for the experience of interacting

and dealing with the intense grief expressed by donor families as often perioperative nurses lacked the skills to deal confidently with these situations.

The third and last theme identified by Carter-Gentry and McCurren (2004) was reported as the “response to participation in organ procurement and associated feelings” (p. 424). This last theme encompassed participant’s feelings which were reported as coldness/emptiness, sadness, depression, helplessness, anger (Carter-Gentry & McCurren, 2004, p. 425). As emphasised by these authors, participants “feelings intensified by senseless/tragic accidents” (Carter-Gentry & McCurren, 2004, p. 425).

In the current study, similar feelings were also identified during the second stage of *being overwhelmed* with their emotional experiences. Two components of emotional experiences were identified, firstly participant’s emotional responses which included many of the responses by the participants in Carter-Gentry and McCurren’s study (2004) such as sadness, shock, distress and anger. Secondly, participants described experiencing nightmares and flashbacks as a result of their participation in procurement surgical procedures. Although this component was not identified in the study by Carter-Gentry and McCurren (2004) the current study has identified in further detail some of the longer term effects on perioperative nurses as a result of their participation in these surgical procedures.

The themes identified in the study by Carter-Gentry and McCurren (2004) were also identified amongst aspects within the current study’s substantive findings. A comparison of the study by Carter-Gentry and McCurren (2004) and the substantive theory both validates the experiences of the perioperative nurses when participating in procurement surgical procedure in addition to supporting the trustworthiness of the current study data and the newly developed theory.

7.4.2 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Regehr et al. (2004) study “Trauma and tribulation: The experiences and attitudes of operating room nurses working with organ donors”

The findings of Regehr et al. (2004) qualitative study of 14 operating room nurses from a large trauma centre in Toronto, Canada also described similarities with the substantive theory of *finding meaning to overcome hiding behind a mask*. Regehr et al. (2004) identified five major themes which were identified from their study, these were described as: organisational factors, responsibilities to patient/family, exposure to death and trauma, coping and attitudes to personal donation. Regehr et al. (2004) reported “that the process of organ procurement from the standpoint of the operating room nurses is highly stressful and raises many concerns and issues for those participating in the surgical removal of organs” (p. 435).

The first theme identified by Regehr et al. (2004) was reported as related to organisational factors which dealt with the long pressured surgeries and relationship with transplant teams. In the current study, organisational factors were identified as an influencing

condition of the basic social psychological problem of *hiding behind a mask*. Long pressured surgeries and the relationship with transplant teams was also identified within the current study but pertained to the first stage of *being unprepared* where participants were confronted with *not knowing what to expect* of the surgical procedure and the needs of external procurement teams.

The second theme described by Regehr et al. (2004) was identified as responsibilities to patient/family which encompassed the donor's well-being, family waiting and family wanting to see the body. These authors explained that nurses within their study were concerned about the "disfigurement of bodies caused by organ and tissue retrieval" and the impact on the donor's family (p. 435). In addition, nurses expressed concern that the "patient may not be dead" (p. 435). Within the current study, these themes were consistently identified during the first stage of *being unprepared* when having to deal with *the grieving family*. Participants throughout the second stage of *being overwhelmed* also reported being concerned for families seeing their loved one disfigured after the procurement surgical procedure. At the same time participants were also overwhelmed at *fears of facilitating the death* of the donor when they also held doubts about whether the donor's brain death status was accurate at the time of undertaking procurement surgical procedures.

The third theme identified by Regehr et al. (2004) was referred to as exposure to death and trauma. This theme encompassed participant's descriptions in graphic detail about their experiences in handling bodies removed of bones and organs and when the respiratory support equipment is shut off. Nurses also expressed having "previous relationships and connection with the patient" when involved in previous operations aimed at saving the patient (p. 436). In the current study, similar findings were also identified within the second stage of *being overwhelmed* which was referred to by participants as experiencing *the graphic nature of the procurement process* when they witnessed the procurement procedure of removing organs and bones. Similarly participants also experienced a connection with the donor patient during previous surgeries however in this study it was only experienced with DCD donors during the first stage of *witnessing the death of the DCD donor*.

The fourth theme identified in the study by Regehr et al. (2004) was described as coping which included the nurses coping strategies. These authors identified "emotional blunting", "focusing on the technical aspects of the job" and "avoiding thoughts about the donor's life and family" (p. 436). Moreover, these nurses focused on the "lives that would be saved as a result of transplant" and sought closure through "a prayer of thanks" (p. 436). Similarly, these themes were identified in the current study and emotional blunting was used by participants in *hiding behind a mask* and when *being overwhelmed*. They choose to hide their emotional responses throughout the surgical procedure by distraction and avoidance. Participant's also referred to focusing on the technical aspects of their roles which in this study was referred to as *getting the job done*.

The fifth theme identified by Regehr et al. (2004) was attitudes to personal donation. These authors indicated that five participants from the sample of fourteen would not be willing to donate their own organs or that of family members. Similar to these results, the current study also identified that twenty three of the thirty five participants were willing to be organ donors regardless of their experiences in procurement surgical procedures. A further five participant's reported that they would not be an organ donor and seven were undecided.

The themes identified in Regehr et al. (2004) study were also identified amongst aspects within the current study's substantive findings. A comparison of this study confirms that the experiences for perioperative nurses is universal with participants in both studies experiencing similar problems and concerns when participating in procurement surgical procedures. The study by Regehr et al. (2004) although has presented similar experiences does not detail how participants in their study resolved their experiences. Therefore the scope of the substantive theory within the current study extends beyond the findings identified within the study by Regehr et al. The substantive theory of *finding meaning* to overcome *hiding behind a mask* has not been described previously in the literature and therefore adds new knowledge and theory to the substantive area. This is the first study within an Australian context which presents the perioperative nurses' experiences of participating in multi-organ procurement surgery. Further, the findings of the current study build on the international body of research by presenting a substantive theory of how perioperative nurses perceive the problem of experiencing *hiding behind a mask* and resolve this by *finding meaning*.

7.4.3 Comparison of the substantive theory of finding meaning to overcome hiding behind a mask with Wang and Lin (2009) study "The experience of perioperative nurses involved in organ procurement"

The findings of Wang and Lin (2009) qualitative study using content analysis of six perioperative nurses from an organ procurement organisation in Taiwan described similarities with the substantive theory of *finding meaning* to overcome *hiding behind a mask*. Wang and Lin (2009) study identified two major parts within their study, these were described as: about the organ procurement experience and about self care. In the first part, the first aspect was labelled as a journey begins at learning. This aspect reported participant's first experiences with procurement surgical procedures. The authors explained that participants often learnt through following instructions from senior staff and if "the senior provides adequate leadership, the organ procurement experience should be more positive" (p. 280). The second aspect was identified as feelings of slaughter where "descriptions of organ procurement focus on the merciless and cruel nature of the process" (p. 280). The third aspect was reported as doubts about death where participants questioned "whether the donor was really dead" (p. 281). Lastly, the fourth aspect was death is a new beginning which was described by participants as "the effect of taking an organ and giving it to a dying patient is very powerful" (p. 281).

In the current study, all four aspects of Wang and Lin (2009) study were identified in various components of the substantive theory. Only a few participants reported being mentored by more senior staff when learning to undertake a procurement surgical procedure with the majority of participants reporting being thrown and *not knowing what to expect* as a result of staff shortages. As noted by the participants in Wang and Lin's (2009) study, they referred to the procurement surgical process as slaughter. Participants within the current student also referred to similar feelings however this was articulated as experiencing feelings of witnessing *the graphic nature of the procurement process*. Moreover doubts about death also surfaced for several participants however this was again during the stage of *being overwhelmed* when participants held *fears of facilitating death* of the donor. Wang and Lin's (2009) fourth aspect described as death as a new beginning was also identified within the process of *finding meaning* and the third stage of *coming to terms*. In the third stage of coming to terms participants were able to recognise the benefits of organs to recipient patients in need via *assisting in preserving life for the greater good* and *focusing on organ viability for recipients*.

The second part of Wang and Lin's (2009) study was referred to as "about self-care" (p. 281). Wang and Lin (2009) described that "skilled and specialised knowledge is needed in organ procurement" (p. 281). To recover from the experience Wang and Lin (2009) identified six self care methods; 1) facing the problem, thinking and adjusting; 2) engaging in leisure activities; 3) holding religious beliefs; 4) separating work from private time; 5) continued self training and 6) sharing. Similarly, in the current study, these aspects were also identified within various components of the substantive theory. In particular several of the self care methods were used by participants in the second stage, *preserving self* of the basic social psychological process of *finding meaning*. The findings identified by Wang and Lin (2009) study were also confirmed within the current study findings. A comparison of this study confirms that the experiences of perioperative nurses when participating in procurement surgical procedures were described within a similar context regardless of the international location. Along with Carter-Gentry & McCurren (2004), Regehr et al. (2004) and Wang and Lin (2009) these studies also supports the trustworthiness of the current study data and the newly developed substantive theory. However, the current study extends beyond the knowledge provided within these studies by emphasising a substantive theory which details the problems experienced by perioperative nurses and how they resolved this. In addition, this study has researched a greater sample of perioperative nurses and has also included the experiences of perioperative nurses caring for DCD donors and the effects of caring for these donors at the time of their death. Further, the substantive theory of *finding meaning* to overcome *hiding behind a mask* broadens and contributes to the body of new knowledge at an international level.

7.5 Summary

This chapter presented an overview of the substantive theory of *finding meaning* to overcome *hiding behind a mask*. Following this a detailed discussion of relevant theories identified within the literature which reflected on important components and elements of the substantive theory were presented. Firstly a comparison was made with Watson's

(1988) “Human Caring Theory” (Watson, 1988). This theory was selected as it provided a comparison of the caring aspects of nursing work. Watson’s theory highlighted several key similarities in how nurses conduct the caring aspects of their work by understanding death and the human caring experiences as referred to Watson as life cycles. Particular similarities were identified in how participants chose to care for donors not only for their soul but on a spiritual level. Parse’s (1981) “Human Becoming Theory” was also included for discussion as it highlighted key concepts in how participants were able to find meaning from their experiences with donor patients. This theory allowed for a deeper exploration and understanding of how participants chose to conceal what they were thinking in terms of their participation in procurement surgical procedures and the need for participants to be *hiding behind a mask* and further understanding the need for participant to engage in the process of *finding meaning* from their experiences.

Kubler–Ross’s (1969) theory on “Death and Dying” added to the discussion by emphasising that nurses as health professionals are also prone to experiencing all the stages of grief and loss when caring for multi-organ donors. Moreover, Lazarus and Folkman’s (1984) theory of “Stress and Coping” addressed several coping methods similarly used by the study participants in assisting them to overcome the problem of *hiding behind a mask* and *finding meaning*. Glaser and Strauss’s (1965) theory on “Awareness of Dying” also provided further evidence of how nurses and health professionals dealt with dying patients and the deceased through various awareness contexts. To add to this study’s trustworthiness, credibility and transferability three more recent international research studies within the perioperative field of procurement surgery conducted by Carter-Gentry and McCurren (2004), Regher et al. (2004) and Wang and Lin (2009) were also presented for comparison with the substantive theory.

Whilst this discussion chapter has identified several similarities amongst both the theories and current research literature, the substantive theory of *finding meaning* to overcome *hiding behind a mask* is unique in that it provides a comprehensive and detailed description and interpretation of the problems encountered by perioperative nurses when participating in procurement surgical procedures and how they move through the process of *finding meaning* to resolve their main concern. The substantive theory captures the multi-dimensional views of each participant through their voices and experiences which have not been documented in depth within the literature. The substantive theory therefore not only highlights the problems encountered by participants but how they resolved their concerns of *hiding behind a mask* through the process of *finding meaning*. This substantive theory not only highlights negative aspects encountered but the positive experiences and rewards in their participation in procurement surgery. This study is therefore more comprehensive and addresses the dearth of information currently not available within the scientific literature.

CHAPTER 8

Research Recommendations and Concluding Statement

"Indeed, our most rewarding moments come when recipients visit us several years or even decades after transplantation, and we find that they continue to live relatively normal lives" (Tilney, 2003, p. 284)

8.1 Introduction

In this concluding chapter of this thesis, the substantive theory of *finding meaning* to overcome *hiding behind a mask* presented the unique experiences of perioperative nurses participating in multi-organ procurement surgical procedures. The findings of this study has emphasised the impact procurement surgical procedures have on perioperative nurses' at the time they are required to participate. It was further revealed that these procedures had personal, physical, psychological and emotional consequences for nurse's who had undertaken this work role. Working in procurement surgical teams from a perioperative nursing perspective has not been explored within an Australian context and therefore the experiences illuminated from the study findings provide a basis for understanding the professional work roles of these health professionals. A discussion of the significance of the study findings, their implications for major stakeholders and relevant recommendations are directed to: perioperative nurses, health services, perioperative organisations, and government and policy makers. This chapter concludes with a discussion of the limitations of the study, including suggestions for future research and a concluding statement.

8.2 Significance and implications of the study findings

The significance of this study is the development of the substantive theory of *finding meaning* to overcome *hiding behind a mask* using a grounded theory methodology. The substantive theory, which has been developed within an Australian context, has provided new insights and a unique perspective of the perioperative nurses' experiences by adding new knowledge and understanding of the issues pertinent to perioperative nurses' when participating in multi-organ procurement surgery. The findings from this study build on the previous findings carried out within the context of international perioperative nursing studies related to procurement surgery, as well as other studies within the substantive area. In addition, the findings provide a theory that describes and explains aspects and components identified within this and other studies (Carter-Gentry & McCurren, 2004; Regehr et al., 2004; Wang & Lin, 2009; Wolf, 1991). Although this is the first study which has developed a substantive theory within this subject area it is important to note that the findings need to be tested within the broader health care areas within Australia to further confirm these findings. However general recommendations can be made to improve the delivery of care towards donors and health professionals who work closely with these procedures. The findings of this study suggest that:

1. The government, policy makers, and health professional organisations in the field of organ donation and transplantation do not understand and recognise

the extent of issues that are encountered by perioperative nursing staff within the clinical setting at the time of participating in procurement surgical procedures.

2. Perioperative nurses' contributions towards procurement surgery are not currently acknowledged, valued or recognised in line with those of other health professionals involved as part of the health professional team.
3. There is a lack of targeted professional education directed towards preparing the perioperative nurse to participate intraoperatively when undertaking procurement surgical procedures.
4. The experiences and well-being of perioperative nurses' along with the impact of assisting in procurement surgical procedures has not been adequately recognised and addressed by governments, health services and policy makers.
5. As health professionals, perioperative nurses provide a vital service to enhancing donation and transplantation rates within Australia. At a national and local level perioperative nursing organisations need to make contributions to policy developments in the area of organ procurement so that their specialised knowledge and skills are recognised and their voice and contributions to organ donation and transplantation are acknowledged and valued.

The findings of this study further extend beyond the current body of knowledge and provides a greater understanding of the psychological, social processes, interactions and experiences faced by perioperative nurses when participating in procurement surgical procedures. The study findings and recommendations are significant and specifically directed to perioperative nurses, surgical teams, health organisations, professional perioperative nursing organisations, governments and procurement organisations to establish the nature of perioperative nursing work in this specialised area of health care. Moreover, initiatives directed towards enhancing aspects of nursing education, health policy, clinical practice and organisational support structures will ensure that support for perioperative nurses and other health care professionals closely involved in procurement surgical procedures within the clinical settings are implemented.

8.3 Recommendations from the substantive theory

The substantive theory of *finding meaning to overcome hiding behind a mask* has implications for health professionals closely involved in the process of organ donation and procurement surgical procedures. This thesis, along with the already disseminated conference presentations (Smith, 2010, 2011, 2012; Smith, Leslie & Wynaden, 2010a) and a published article (Smith, Leslie & Wynaden, 2010b) provide an insightful account of the Australian perioperative nurses' experiences of participating in procurement surgical procedures. Several implications and recommendations can be made which emanate from

the study findings and encompass four distinct areas: 1) recommendations for perioperative nurses; 2) recommendations for health services; 3) recommendations for professional perioperative organisations and 4) recommendations for government organisations.

8.3.1 Recommendation for perioperative nurses

The first implications and recommendation of the findings of this study is directed to perioperative nurses along with initiatives to assist them to be better prepared when participating in procurement surgical procedures. Three initiatives in this area have been identified: 1) clinical nursing practice, 2) perioperative nursing education and 3) professional support. Each of these initiatives will be presented.

8.3.1.1 Clinical nursing practice

The findings of this research study have important and direct implications for perioperative nurses in clinical nursing practice. The role of perioperative nurses in this expanding area of organ procurement surgery has remained largely hidden *behind the closed doors* of Australian operating rooms. The isolating work environment of perioperative nurses whilst undertaking these surgical procedures has emphasised the need for these nurses to be *hiding behind a mask* their experiences within these surgical procedures. These findings acknowledge and recognise the psychological, social processes, hidden fears and doubts perioperative nurses experience and the complex issues which confront these nurses at the time of having to participate in procurement surgical procedures.

The research findings further emphasises the need for *work conditions* to be modified when these surgical procedures are to take place. Firstly the theatre culture has been reported as exacerbating perioperative nurses' behavior towards suppressing their abilities to cope with emotionally demanding procedures such as procurement surgery. As noted by several participants the work culture of perioperative nursing often shunned nurses who appeared not to be coping thereby increasing nurses *hiding behind a mask*. An open awareness of both the emotional personal and professional impact of these procedures will ensure that all perioperative nurses are more accepting and tolerant of the needs and well-being of other staff members within the clinical setting. This study also highlighted attitudes and judgmental practices took place which further indicated that support was lacking amongst perioperative nursing professionals. This lack of support had detrimental effects to individual nurses seeking support from their immediate peers hence continuing to exacerbate the problem of *hiding behind a mask*. Therefore initiatives which promote a positive work culture and recognition of the need to talk about traumatic issues will help limit the isolation perioperative nurses feel and promote a more positive and cohesive work environment which encourages nurses to cope with traumatic aspects in their own way without being judged.

Increased clinical exposure to procurement surgical procedures needs to take place so that as many nurses can experience such procedures prior to being involved at short notice. Perioperative nurses who are aware of the potential for procurement surgical procedures to take place within their departments must ensure that they have access to the latest

procedural information about these procedures and their potential roles. Nurses need access to clinical resources and the ability to clinically prepare themselves prior to assisting in these surgical procedures to promote a better understanding of the procurement process and the role of the perioperative nurse. Where transplantation procedures are undertaken within the nurse's hospital setting exposure to these procedures would be beneficial. The study by Blumenthal (2007) on organ donation coordinators also emphasised the importance of contact with recipient patients "interaction with recipients may also benefit staff... these kinds of opportunities may add to their feelings of personal fulfillment" (p. 20). This aspect was reinforced by several participants within the current study who explained that being exposed to recipient patients during transplantation surgery often reinforced the positive aspects towards the organ procurement surgical process and *finding meaning* from their work roles.

The ability for perioperative nurses to have a conscientious objection and openly state this without any ramifications is another implication of this study. Perioperative nurses need to have a voice and be able to assert a conscientious objection if they have a moral, ethical or religious objection to participating in these surgical procedures. Several nurses indicated that as a result of having a conscientious objection they avoided procurement surgical procedures by changing their on-call or avoided coming in to work early so they would not have to relieve night duty staff already involved in the procedure. Other participants also expressed experiencing personal discomfort whilst participating and although they voiced this to their line managers they felt they were not heard. Therefore, initiating open channels of communication amongst staff within the clinical area would ensure that everyone is heard impartially.

Perioperative nurses also need to voice their concerns in regards to their need to provide what they term as adequate post mortem care. Several participants when caring for organ donors throughout the procurement surgical procedures could not complete the process of ensuring adequate post mortem care as a result of being taken away from completing this duty and were not able to gain closure or find meaning from their participation. Therefore it is vitally important that nurses can follow through with providing post mortem care to donors as part of completing these surgical procedures so as they can gain some semblance of personal closure.

8.3.1.2 Perioperative nursing education

The findings of this study have important implications for perioperative nursing education related to procurement surgical procedures. The disparity in the levels of knowledge, experience, exposure and understanding of procurement surgical procedures increased participant's experiences of *hiding behind a mask*. The majority of participants in this study disclosed that they had not been provided with any forms of education prior to assisting in a procurement procedure. Participants also stated that they were never provided with mandatory education on procurement surgery or organ donation as part of their theatre induction or as part of a program of continuing education which is usually provided by a theatre educator or staff development nurse within their operating suite unit. Many participants were therefore unprepared for assisting clinically in procurement surgical

procedures, lacking knowledge on the procurement process and what was expected of them when participating in these surgical procedures and also unprepared emotionally for what they would see and do as part of their roles. Several nurses described *being overwhelmed* by the lack of exposure and experience to confidently participate in procurement procedures, in addition to experiencing fears of facilitating the donor's death as a result of lacking understanding of the organ donation process, brain stem testing or the DCD process.

Initiatives to increase further education and training on aspects of the procurement surgical process prior to donors coming to theatre, in addition to education on brain stem death testing and the process of DCD donors is vital. In the current study findings several participants were overwhelmed with *fears of facilitating death* of the donor as a result of lacking understanding and knowledge of brain stem testing. These findings were also supported widely within the literature by other authors who also indicated lack of knowledge and doubts about brain stem testing results (DuBois & Anderson, 2006; Floden & Forsberg, 2009; Sadala et al., 2006; White, 2003). Specific education on the concept of brain stem testing should be provided to all staff who are involved in the procurement surgical procedure to ensure that staff have an understanding that donors are in fact deceased prior to these surgical procedures taking place. This will assist in alleviating their fears as a result of understanding the concepts and processes undertaken to determine a brain death diagnosis.

Specific education tailored to the roles of perioperative nurses intraoperatively in a safe and supportive environment is also required as this will help to increase the knowledge base of these nurses and ensure that they are not *hiding behind a mask* their lack of knowledge or concerns related to these surgical procedures. This aspect was also raised by other authors, such as Watkinson's (1995) earlier study who emphasised that "the learning environment must be suitable, ensuring physical comfort and, importantly emotional safety" (p. 939). Other authors have also identified that insufficient education provided to health professionals closely involved in the procurement process continues to be a problem globally (Collins, 2005; Floden & Forsberg, 2009; Jacoby et al., 2006; Kim et al., 2006; Meyer et al., 2011).

In the current study, increased exposure and clinical mentorship was reported as an excellent form of accessing on the job clinical skills towards procurement surgical procedures. Participants from the current study benefited from this exposure and found these experiences useful however due to limited staffing numbers and opportunities they were not always able to utilise such opportunities. Initiatives to increase exposure for perioperative nurses through mentoring in procurement surgical procedures would be beneficial as nurses would feel less stress and strain having to manage these procedures on their own and with limited knowledge and exposure. This would in turn help to alleviate the overwhelming clinical skills demands placed on individual nurses at the time of participating in a procurement surgical procedure and would also aid the nurse to address and focus on the emotional demands of participation which is vitally important to their well-being and their ability to cope.

As the study findings indicated, the only current mode of professional education reported by the study participants was attendance at courses such as ADAPT. This course is designed for all health professionals however did not meet the specific intraoperative surgical and educational needs of the study participants. Although the ADAPT course provides an overview of the organ donation process and has been reported as a valuable basis of information, it is recommended here in conjunction with specific theatre education which could entail the following adjuncts: a national perioperative nursing specific workbook which is distributed to all preoperative nurses Australia wide; the development of a short documentary video/movie of the two types of donor patients (brain dead and DCD) and the process of establishing suitability for donation; professionally conducted workshops with simulated perioperative training experiences would also be of benefit to perioperative nurses to experience such procedures within a safe and non threatening environment.

As noted in the current study findings, barriers to accessing education related to organ donation and procurement surgery were noted as staffing shortages within the operating room which resulted in staff not being given time release from their work environment to attend such education sessions. Another barrier identified by rural and regional area perioperative nurses was not having access to such education or in-services due to their location. Therefore initiatives for perioperative nurses to access education on all facets of organ donation and procurement surgery must also take into account the educational needs of nurses working in these regional and rural areas.

Education programs specific to perioperative nurses need to also include opportunities for exploring the emotional reactions of participants towards these surgical procedures. An emphasis on attitudes to donation and how perioperative nurses own values and beliefs might impact on their participation in procurement surgical procedures needs to be included. As noted by the study participants some indicated a strong desire to conscientiously object however carried the burden of hiding an objection to participate to these surgical procedures when their own values and beliefs were challenged as a result of prior participation. This aspect was supported in other study findings where it was highlighted that nurses and the public held varied attitudes and beliefs on organ donation and procurement surgery (Haddow, 2005; Kim et al., 2004b; O'Carroll, Foster, McGeechan et al., 2011; Pelletier, 1992; Thompson et al., 2004).

Initiatives to promote education and a greater awareness of death and dying within the operating room context will also assist perioperative nurses to better understand this process and manage issues accordingly. Education on death and dying is poorly promoted within the operating room often as a result of the work environment which usually deals with saving lives and restoring patient's well-being through surgical procedures. It is common for death and dying education to be conducted during undergraduate nursing courses which encompasses how to provide care towards dying patients however the psychological aspects and effects on health professionals is often an overlooked area. As noted from the study findings several participants wanted to avoid the fact that they were operating on a deceased donor as dealing with death was not a common occurrence within operating rooms. Unfortunately staff did not have adequate skills to deal with such events and felt overwhelmed when dealing with patients who were deceased. Several

perioperative nurses expressed that they worked in the theatre environment so that they could avoid contact with patients and family. This was similarly noted by Glaser and Strauss (1965) when stating “many nurses frankly admit a preference for wards or fields of nursing where there is little confrontation with death” (p. 5).

Initiatives with an aim to increase education on death and dying in general terms should also encompass the psychological effects of death and dying on perioperative nursing health professionals. It will also be of benefit if specific education with a perioperative nursing focus on how to better provide spiritual care to patients within an operating room context is also provided. In the current study several nurses explained that they felt uncomfortable and an awkwardness in how to care for deceased donor patients within a team environment. Other nurses spoke of lacking general knowledge on how to provide spiritual care to deceased patients who had died within the operating room. As care is predominantly provided within a team framework, several nurses felt uncomfortable initiating aspects of spiritual or postmortem care that they would have completed if on their own. This made several nurses feel that the care they provided was fragmented and they could not gain closure when they had not provided a high standard of care or the care they wanted to provide. These findings were also confirmed by previous researchers (Carter-Gentry & McCurren, 2004; Regehr et al., 2004; Wang & Lin, 2009; Wolf, 1991).

The findings of this study would suggest that within the operating room setting there is no available education which deals with death and dying, and how to care for patients who have died within an operating room context. Several nurses disclosed having undertaken this task whilst referring to a policy procedure manual as a reference to guide their practice and care. Within a broader context a lack of knowledge and awareness of death and dying within the operating room environment also does not prepare these specialised nurses to deal with bereaved families who come into the operating room environment to see their loved ones. Several perioperative nurses therefore did not have the knowledge base or skills to talk with these bereaved families, and they tried to avoid such encounters. This was evident when nurses reflected that they felt uncomfortable dealing with the families of both brain dead and DCD donors. Therefore education dealing with bereaved families will assist perioperative nurses to deal with these encounters in a more positive and favourable way as increased family presence of DCD donors becomes more prominent. Greater awareness of death and dying issues may assist nurses to further feel more comfortable in adopting a holistic approach to care such as providing adequate post mortem care in a very busy theatre environment. Initiation of these recommendations will help to initiate a culture where death and dying and the effects on health professionals is more open and transparent. Perioperative nurses will no longer have to continue to be *hiding behind a mask* the emotional aspects of their work and their lack of knowledge or inability to cope as a result.

Lack of education for all professionals in organ donation and transplantation continues to be a problem not only in Australia but internationally. Several authors have documented the need for all professionals in the process of organ donation and transplantation to continue engaging in continuing education and to update their knowledge and clinical skill base (Essman & Lobovitz, 2005; Lopez–Montesinos, Manzanera Saura & Mikla et al., 2010;

O'Carroll et al., 2002; Tokalak et al., 2005). As noted by the current study findings further targeted education for perioperative nurses is vital to ensure that they are adequately prepared and continually trained to undertake procurement surgical procedures.

8.3.1.3 Professional and peer support

The findings of this study provide important implications for the need for both professional and peer support for perioperative nurses within their work environments. Several participants reported *being overwhelmed* and traumatised by their experiences when participating in procurement surgical procedures. Not having any forms of professional and peer support exacerbated their behaviours of *hiding behind a mask*.

It was noted in the study findings that the impact of procurement surgery predisposed some participants to suppress and not speak about their experiences or concerns for several years. These participants explained that this occurred as a result of a lack of timely access to professional or peer support which was never forthcoming for whatever reason. This in turn led to the exacerbation of longer term psychological effects such as *nightmares and flashbacks* with intrusive thoughts long after their participation experience. Therefore the need for perioperative nurses to have access to timely professional support so as traumatic and stressful experiences do not compound over several years should be a basic prerequisite for all health professionals involved in the surgical process of procurement surgery. Several participants emphasised the problems they encountered in both their personal or professional sphere when not having timely access to informal or formal debriefing with peers let alone professionals immediately after a procurement experience. Several nurses also felt that they would seek professional support if it was made available however they required this to be provided shortly after the experience not some two to three weeks after having participated in such an event. Other authors have also spoken about the need for health professionals to seek timely professional support (Blumenthal, 2007; O'Connor & Jeavons, 2003b; Wagner, 2005; Watkinson, 1995). The earlier study on critical care nurses caring for organ donors by Watkinson (1995) reinforced this notion by the following recommendations:

Debriefing sessions should occur routinely as part of the working day and not be seen as a 'add-on extra' when something particularly alarming occurs. This will help destigmatize the notion that only weak individuals need support and explanation. We all do at sometime. (p. 939)

More recently this aspect was also supported in the study on donation coordinators by Blumenthal (2007) who emphasised "donation coordinators must be encouraged to access whatever resources are available to nourish them" (p. 21).

Another important component of professional and peer support is initiatives to assist and teach perioperative nurses effective coping skills and the need to reach out to available support networks when dealing with traumatic situations within the work environment. Such coping skills could be initiated through access to professional and peer support programs both through formal and informal counselling and debriefing sessions. In the current study findings, increased *levels of support* from peers, through *intraoperative*

support was also identified as beneficial and an important condition in influencing the participants experiences of *finding meaning*. An operating room culture which encourages increased support to staff via communication, and open disclosure about staff's concerns will foster a more supportive work environment with decreased judgment and discrimination. Therefore initiatives which promote a caring culture towards the emotional needs of perioperative nurses will help reduce stigmatisation of staff that may require additional supportive assistance within the work environment.

Perioperative nurses should also be encouraged to set time away from their work roles such as having an extended tea break after assisting in such surgical procedures so as they can tend to their own well-being. This will ensure nurses have an opportunity to deal with the stress and demands of their experiences by having an opportunity in which to unwind whilst also having an opportunity to process their thoughts and emotions. Such measures have been reported within the current study findings as helpful in assisting nurses in *finding meaning* not only in their work roles but in their ability to cope as a result of *preserving self* through *established coping mechanisms*.

8.3.2 Recommendations for health services

The second implication and recommendations of the findings of this study is directed towards health services. It has been recognised that specific initiatives directed towards health services will ensure that appropriate services and work practices are implemented within the hospital environment to support both nurse managers and the health professionals they manage when undertaking their roles in procurement surgical procedures. Two initiatives have been identified and are directed towards: 1) hospital organisations and 2) nursing management.

8.3.2.1 Hospital organisations

As noted in the study findings hospital organisations need to ensure that they have appropriate work environments and resources to deal with procurement surgical procedures at the time these surgical procedures are required to take place. As indicated by participants, in an Australian context typically there are no dedicated perioperative nursing teams for procurement surgery. These surgical procedures are undertaken by the available operating suite nursing staff at the time these procedures are required. As reported by the majority of study participants, they were often thrown into such procedures without warning and lacked experienced staff backup if assistance was required. Therefore, a partnership approach needs to take place where hospital organisations provide education, training resources and support to health professionals to manage their involvement in undertaking such specialised procedures.

Hospitals organisations need to take responsibility for the potential possibilities of having adequate staff available to undertake such procedures ad hoc so that staff resources are not stretched and perioperative nurses are not undertaking additional work duties such as overtime to accommodate these procedures. This can lead to nurses being overworked and burnt out with little ability to care for their physical and emotional well-being. Hospital organisations should have available adequate staffing levels, and have backup on-call teams

to ensure that perioperative nurses are not working overtime with little ability to cope and recover from these surgical procedures. As noted in the current study findings several participants spoke of the negative impact of dealing with *increased workloads*, by being fatigued and stressed when working overtime as a result of *waiting for procurement surgery* to take place and working under pressure with limited staff undertaking such procedures. Due to staffing issues several participants were also given additional duties to undertake immediately after a procurement surgical procedure which left several participants with no avenues to seek respite, or attend to their own well-being. Hospital organisations need to have adequate support resources such as counselling or debriefing sessions available to their staff not only prior but post participation in such procedures.

Initiatives from hospital organisations should also encompass the need to ensure adequate resources such as providing a conducive work environment to successfully undertake procurement surgical procedures. Individual organisations should put in place initiatives to adequately prepare, train and up skill all perioperative nursing staff who potentially will be assisting in procurement surgical procedures. Hospital organisations also need to ensure that all perioperative nurses are continually and professionally competent and updated on current practice issues to undertake such surgical procedures. If further training is required they need to ensure that nurses have access to professional development study days to undertake further educations and skills updates. In particular, hospital organisations within the rural and regional areas need to ensure that staff have access to such training and provide them with means to access this training.

Each organisation should have available, appropriate and updated policy manuals which should be maintained regularly to reflect current procurement practices. This will ensure that perioperative nursing staff have available up to date information at hand should they require access to these resources afterhours. In addition, hospital organisations need to also take responsibly to ensure that they have relevant surgical equipment within their hospital to undertake procurement procedures successfully. Several participants spoke of undertaking such surgical procedures without having the appropriate surgical equipment available. Although this would seem as an expected prerequisite given organisations have made a commitment to undertake such surgical procedures this was obviously not occurring. Often some organisations were relying upon external procurement surgical teams to provide this equipment. However this is not best practice as due to unintentional mishaps, equipment can become unsterile and the need to have immediate access to sterile equipment should be a priority without waiting for lengthy resterilisation of equipment. These potential delays could hamper organ preservation times and the possibility of successful transplanting specific organ within the ischaemic timeframes for recipient patients. Therefore hospital organisations should not rely on external procurement teams to provide this surgical equipment.

Hospital organisations can also initiate relevant professional support strategies to be available for all staff at the time procurement surgical procedures take place. As noted in the current study, one participant brought in a professional counsellor into the operating room at the time of an organ procurement surgical procedure to increase understanding of the impact of these surgical procedures on staff. This gave the counsellor insight into what

the experience was like firsthand so as she could support staff involved in future procurement surgical procedures. Each hospital organisations can tailor specific support programs for these groups of health professionals.

The current study findings could be used by professional psychologists and counsellors to gain further understanding of the issues expressed by participants and act to assist health professionals closely involved in the process of organ donation and procurement surgical procedures. Although it would be ideal to have a professional counsellor or psychologists on site, or within the institution at the time a procurement surgical procedures takes place it is acknowledged that this may not always be practical. Therefore individual hospitals should ensure that other means of support are available and provided to staff even though the work environment may preclude this at times. Hospital organisations can also implement a hospital based grief team for all nurses and staff who experience a patient death. Within the literature Brosche (2007) emphasised the importance of establishing an onsite grief team reporting benefits such as “transforming relationships and in reaffirming the spirit and the work of the nurses and the staff” (p. 28).

Hospital organisations play a vital role in initiating change. They are responsible for allocating adequate resources to the level of care delivered. Without their support it is difficult for operating room department managers to implement work practices to ensure that there are adequate staff levels and support to nurses at the grass roots when undertaking procurement surgical procedures. Therefore it is vital that hospital organisations implement relevant initiatives and act in a timely manner to support not only operating suite managers to provide such vital resources but the health professionals who undertake these procedures.

As noted in the current study findings, one hospital organisation initiated successfully such measures after perioperative nurses sought support from the hospital organisations Director of Nursing in a regional area. The Director of Nursing took the nurses concerns on board and by initiating *better work conditions* for perioperative nursing staff involved in these surgical procedures as a direct result of the concerns they had raised. These initiatives included having a separate on-call team who was called in to assist only with the procurement surgical procedure, the provision of food provided for the whole team (hospital based and external procurement teams) who had undertaken the procurement surgical procedure, allocated time to appropriately care for the organ donor at the time of providing post mortem care and lastly adequate time for staff to personally recover after the surgical procedure. As a result of the Director of Nursing recognising the need of the staff, there was an increased awareness of the needs of staff within the operating room and quick action produced positive benefits for all involved in the procurement surgical process.

8.3.2.2 Nursing management

The findings of this study also have important implications for nursing management within the perioperative specialty. As indicated within the data, several participants worked in procurement surgical procedures without wanting to participate and unfortunately had to take part in these procedures regardless as a result of no other staff being available at the

time. Several participants also spoke of working under staffed, with limited resources available to them at the time of undertaking procurement surgical procedures. They also worked in a theatre culture where they had to suppress their emotional reactions and cope regardless of their own personal issues and well-being. These situations had a negative impact on the participants thereby predisposing them to be *hiding behind a mask*. The findings also identified that although some participants lacked nursing management support they still continued to maintain their professionalism under extreme stress and trauma.

Frontline managers and coordinators need to ensure that staff needs are met within the operating theatre environment at the time of a procurement surgical procedure. Managers need to be acutely aware of the individual needs of their employees, their respective strengths and weaknesses in addition to their ability to cope within such a surgical procedure. It is imperative that they are alert to the clinical implications of these surgical procedures not only on their departments but the effects on perioperative nursing staff. A greater emphasis needs to be placed on the well-being of staff and not on theatre productivity, budgets, theatre utilisation and key performance indicators. As indicated in the study findings nurse managers who were able to instill a positive work culture, environment and *better work conditions* ensured that their staff were well managed and supported within the work environment. This ensured that several participants who worked under such a manager were more comfortable and able to seek support from the surgical team, working as a team *united as one* with procurement surgical teams and were individually *finding meaning* as a result of their participation in procurement surgical procedures. Therefore initiatives by nursing management which instill a positive work culture, which encouraged nurses to seek and report concerns, which emotionally and physically supports perioperative nurses needs to be fostered, emphasised and implemented within an organisation.

As identified in the study findings managers need to acknowledge that for certain nurses procurement surgical procedures may have impinged on their personal values and beliefs. Therefore managers need to provide opportunities for nurses to express their concerns in a safe and non-judgmental environment. They need to ensure that they validate the concerns of staff in regards to a conscientious objection and listen to the personal concerns of their employees by putting in place measures to support them within the clinical working environment. Managers could implement such strategies as asking perioperative nurses within their departments who would like to participate in these surgical procedures and focus on up skilling and training these professionals to be better prepared for these surgical procedures in advance of their participation. Earlier literature also supports this premise, Crandell (1987) emphasised “managers should not force those who are unwilling to participate to do so unless absolutely necessary” (p. 946).

Managers who are aware of procurement surgical procedures taking place within their departments should also ensure they provide additional staff to cover the eventuality of procurement surgical procedures. This would ensure that staff are not overworked and dealing with increased workloads with little ability and time to recover in between surgical procedures and procurement surgery. This would enable staff to balance their stress levels.

Unfortunately this is not always possible to initiate in theatre departments who lack staff numbers however clever management of skill mix amongst staff and relief opportunities may limit the impact of nurses being overworked, stressed and feeling overwhelmed.

A lack of support following a procurement procedure was also noted within the findings of this study suggesting the need for nursing management to implement initiatives for perioperative nurses to have timely professional support immediately after procurement surgery. Managers also need to acknowledge the benefits of appropriate support for perioperative nurses and ensure that support is provided. This aspect has been supported within the literature where some authors have asserted the documented benefits in receiving debriefing sessions immediately after a critical incident (Brosche, 2007; Ireland et al., 2008; Lunn, 2000; O'Connor & Jeavons, 2003b).

Participants in the current study also identified the need for personal professional counselling sessions to alleviate the traumatic impact of procurement surgical procedures however noted that they were not given time to be released from work in which to access these services. As the trauma is inflicted and related to a work role, nursing managers must initiate adequate resources to allow staff to access these professional services during work hours and in a timely manner to coincide with the individual needs of the nurse.

8.3.3 Recommendations for professional perioperative organisations

The third implications and recommendations of the study findings are directed to national and state professional perioperative nursing organisations. It is imperative that professional perioperative organisations act to raise awareness of the perioperative nurse's contribution to both procurement and transplantation surgery and the needs of their members in addition to implementing relevant standards and practices. Two initiatives have been identified and are directed towards the: 1) national professional organisation ACORN and 2) local state perioperative organisations.

8.3.3.1 National professional organisation ACORN

The findings of this study have important implications for the national professional association, the Australian College of Operating Room Nurses Inc (ACORN). As noted in the study findings there is currently no position statement, standards or directives for perioperative nurses to follow or refer to in regards to organ donation and transplantation from their national organisation ACORN. On closer inspection of Australian policies related to organ procurement and donation, it is also noted that ACORN have not been consulted to provide input on clinical aspects of undertaking procurement surgical procedures within the operating room environment. Every government document to date has not had input from this specialty area when policy directives on organ donation and transplantation have been made. The study findings also revealed that the participants were concerned about lack of support and appreciation for their work at a national level. Given the major commitment perioperative nurses make towards successful procurement surgical procedures, their involvement and contribution should be recognised at a national level so as adequate training and support can be provided to this group of health professionals. Therefore, it is timely and crucial that initiatives by ACORN be implemented to raise

awareness of perioperative nurses involvement in procurement surgical procedures. It is also vitally important that ACORN liaises with policy makers to initiate best practice within the clinical setting of the operating room environment and that adequate care is provided to organ donors and perioperative nurses involved in these surgical procedures.

The findings of this research have been presented at two national ACORN conferences to raise awareness of the issues identified within the research study (Smith, 2012; Smith et al., 2010a). These presentations were well received as several members attended these sessions with delegates reporting identifying and acknowledging the findings of the study with the researcher. These sessions also sparked extensive discussion validating the keen interest perioperative nurses had in finding a solution of how to better meet the needs of perioperative nurses and their profession within this expanding field. It is anticipated that these study findings can be a starting point to raising awareness of the issues pertinent to this specialty group and appropriate standards and practices can be implemented at a national level.

To date there are no standards released by ACORN which provide specific guidance for the latest's developments on education to support perioperative nurses in their roles, education and practice issues on brain death organ donation or donation after cardiac death (DCD) donors. Although ACORN do not have a specific standard in regards to organ donation and transplantation they do have a standard for "Emotional Support for Personnel" where they document that staff should have emotional support for specific traumatic events such as organ procurement and transplantation (ACORN, 2012). Therefore, initiatives by ACORN in disseminating further information would be beneficial. In particular it is also crucial that ACORN establish some guidelines and standards which are endorsed by ACORN to ensure best practice by perioperative nurses as a basis to understand the challenges of procurement surgical procedures and clinical issues contributing to this expanding area as a professional body.

It is also timely that ACORN represent Australian perioperative nurses on relevant committee's and organisations that are developing national policies and directives on organ donation and transplantation. As noted several other specialty groups; critical care and intensive care nursing organisations have been consulted and recognised within the Australian government publications however ACORN has not been consulted on policy developments. Given the major contribution perioperative nurses make towards these surgical procedures it is important that this group of health professional be consulted to improve not only organ donation successes but to improve support to those health professionals closely involved in these procedures.

It is anticipated that some of this study's findings can be utilised in assisting policy makers to review current practices to ensure that operating room staff have relevant resources and timely support available to undertake procurement surgical procedures at a very high standard. As a specialty professional organisation ACORN can also assist by having a voice and promoting organ donation and transplantation at a national level. The organisation can work with policy makers in providing relevant and specific education at a national level to perioperative nurses.

8.3.3.2 Professional state organisations

As noted in the study findings, it was identified that each state has different legislation pertaining to organ donation and practices in regards to care of organ donors undergoing procurement surgical procedures. At the time the study was undertaken only NSW perioperative nurses were undertaking DCD procurement surgery. It was identified from the participants from NSW that more education and knowledge was required for nurses to participate comfortably within these procedures. Several nurses were not prepared for treatment being ceased and *witnessing the death of the DCD donor* and having exposure to the *grieving family*. Therefore professional state organisations such as in this case, the New South Wales Operating Theatre Association (NSW OTA) could implement initiatives which provide supplementary education sessions, workshops and support resources to state perioperative nurse members to assist them to undertake procurement surgical procedures successfully. This will ensure that perioperative nurses have support at a state and local level. In addition, it is also timely that professional state organisations represent perioperative nurses on relevant committee's and organisations that are developing state policies and directives on organ donation and transplantation so that their voice is heard on issues that impact on their practice related to these surgical procedures.

8.3.4 Recommendations for government organisations

The fourth implications and recommendations of the findings of this study is directed towards government organisations with initiatives which emphasises the need for organisations such as DonateLife to improve services, resources and support for perioperative nurses involved in undertaking organ donation and transplantation procedures within Australia. Two initiatives have been identified and these are directed towards the: 1) Australian government and 2) DonateLife. Each of these initiatives will be presented.

8.3.4.1 Australian government

The findings of this study have important implications for the Australian government. The Australian government has invested Commonwealth funding to increase resources and training of health professionals and the community to facilitate increases in organs procured and transplantations for the Australian community (Organ & Tissue Authority, 2010). Since the establishment of the National Australian Organ Donor Register further work has been undertaken in building the National Organ Donation Collaborative (NODC) in 2006. The NODC is made up of 26 hospitals with teams of qualified health professionals to promote best practice models and develop evidence based guidelines and interventions to promote organ donation and transplantation. Moreover, the Council of Australian Governments (COAG) in 2008 released the Australian Government's National Reform Agenda on organ and tissue donation for transplantation. The objectives of the National Reform Agenda are to:

“increase the capability and capacity within the health system to maximize donation rates; and raise community awareness and stakeholder

engagement across Australia to promote organ and tissue donation”.
www.donatelife.gov.au)

The Organ and Tissue Authority are responsible for implementing education on organ donation and transplantation as provided by the Australian Government’s National Reform Agenda on organ and tissue donation for transplantation. As recognised within the current study, the Organ and Tissue Authority (2010) strategy and policy has limited or nonexistent clinical applications within operating rooms. The findings have identified that as a professional group perioperative nurses lacked education, training opportunities and support in their work on organ donation, procurement surgical procedures and transplantation. Based on this study’s findings government organisations need to re-examine initiatives already implemented to ensure that they are targeting all health professionals who are involved in these procedures, specifically health professionals such as perioperative nurses.

Government organisations also need to implement initiatives which promote the well-being of health professional closely involved in procurement surgical procedures. Initiatives such as employing specially trained counsellors and psychologists in organ donation and transplantation will ensure that these professionals have understanding of the process and can better support the needs of health professionals closely involved. Moreover, these health professionals should also have clinical exposure to the procurement surgical procedures so as they have knowledge of the process and can understand the needs of perioperative nursing staff when closely involved in procurement surgical procedures.

Further, Government organisations can also liaise and consult with professional perioperative nursing organisations on their profession’s needs. This can then form part of the wider organ donation and procurement strategy and policy.

8.3.4.2 *DonateLife*

The findings of this study also have important implications for DonateLife who have been identified as the only source of providing education to perioperative nursing staff. It would be of benefit for organisations such as DonateLife to be aware of this study’s research findings so as they can implement the best available education to all health professionals inclusive of the specific needs of the perioperative nursing profession. Initiatives for DonateLife and state donor organisations could also recognise the concerns, problems encountered and issues reported by the study participants within this study and address these through appropriate means.

As indicated by the study participants the state DonateLife agencies have provided in-services and the ADAPT Course. Although these education services have been utilised as indicated by several study participants they felt these education in-services were brief, provided only limited information on the organ donation process and did not relate to the intraoperative educational needs of perioperative nurses. In particular several areas of education were lacking which left these health professionals with knowledge gaps at the time of participating in procurement surgical procedures. These knowledge gaps were

reported as brain stem testing and diagnosis; the stages of the procurement surgical procedure and care of DCD donors and the processes involved.

Relevant strategies need to be implemented to further promote education on organ donation and procurement and the impact on perioperative nurses participating in these procedures at both a national and state level. Donate Life state organisations could also initiate more regular education sessions through national and state conferences. The implementation of relevant educational tools and professional resource for these health professionals needs to take precedence as organ donation continues to expand and evolve. In particular, further education on dealing with DCD donors and the effects of these donors on perioperative nurses prior to conducting procurement surgical procedures.

The study findings also indicated that organ donor coordinators were a positive influence on perioperative nurses when providing not only mentorship on aspects of the procurement procedures but emotional support for perioperative nurses at the time of their participation in these surgical procedures. Although emotional support was reported as beneficial several perioperative nurses spoke of requiring further support which unfortunately could not be met by organ donor coordinators due to their own work commitments.

It would also be beneficial for perioperative nurses if they were recognised for their contributions in procurement surgical procedures. Several participants spoke of receiving a thank you letter from state donation organisations. This validated their contributions towards these difficult procedures and assisted perioperative nurses in *finding meaning* from their experiences. As an extension of this, it would be beneficial if perioperative nurses were invited to attend donor remembrance days where they can also liaise with other health professionals closely involved in these procedures, in addition, to meeting recipient patients who have received organs. This would further reinforce the positive aspects of organ donation and further *finding meaning* from their contributions towards these surgical procedures.

Another important initiative is that of the need for organ donation organisations to continually collaborate with health services, professional perioperative nursing organisations and perioperative nursing staff on a regular basis to meet the changing needs of all involved at a national and state level. Regular collaboration will also ensure all stakeholders are up to date with new trends in organ donation and transplantation policies and clinical practices to ensure that best practice standards are maintained within this specialised field of work.

8.4 Limitations of the study

The substantive theory of *finding meaning* to overcome *hiding behind mask* presents the findings of perioperative nurses' experiences of participating in procurement surgical procedures. It is acknowledged that this study has some limitations which need to be taken into account when considering the research findings. As indicated by Bloomberg & Volpe (2008) "no research project is without limitations" (p. 79). Therefore recognition of the

study limitations is important as it exposes the conditions which potentially can weaken a study (Rossman & Rallis, 2003). Four limitations were identified for this study.

The first limitation is the selection and use of participants from only two Australian states; New South Wales and Western Australia. It is recommended that further studies be conducted using a larger and more representative sample of perioperative nurses from other states in addition to including a broader range of participating health institutions to support conceptual transferability at a national level.

The second limitation is the self selection of participants who all came to the study after responding to advertised flyers calling for perioperative nurses to share their experiences in procurement surgery. It can be viewed that those who chose to participate may have been more comfortable to discuss their involvement in multi-organ procurement procedures and their individual experiences. Nurses who were not happy to talk about their experiences may have felt inhibited to participate in the study as there may be a perception that they aren't able to cope with the demands and difficult nature of perioperative nursing work in this area. Therefore, this study may have over selected or recruited the least affected nurses to discuss their individual experiences. Further, given the broad range of experiences this study may have also attracted participants who wanted to express and share the negative experiences of their participation in procurement surgery.

The third limitation identified is the fact that at the time of data collection only participants from NSW were undertaking DCD procurement surgical procedures. In Western Australia, donation after cardiac death donations were not conducted at the time of collecting data as a result of waiting for relevant legislation to pass. Therefore, participants in NSW undertaking DCD surgical procedures lacked experience with these new procedures so the issues may not have been fully identified and articulated by the participants at the time of data collection from 2009-2010. Therefore this could be viewed as a limitation of the study.

The fourth and final limitation was the use of the grounded theory methodology which focused on the generation of a substantive theory from the data collected. The developmental nature of the grounded theory method allows for participants to voice their concerns thereby only representing the core category. As the perioperative nurses were able to speak of the concerns that mattered to them this may be seen as a limitation as the researcher was unable to diverge in other topics areas that were raised however may have been irrelevant to the theory development. Glaser (1998) notes that when a researcher undertakes a dissertation "their developmental problem is to get through the coding stage. They have to learn to avoid incident tripping, impressioning out and conceptual description and move on to generate an integrated conceptual theory" (p. 45). Further, the process of grounded theory is to identify a substantive theory rather than testing the findings. Therefore the extent and seriousness of the issues raised by the participants is not necessarily apparent through this approach. Once a theory is developed it requires further rigorous testing to build and quantitate the issues identified by conducting further research within the substantive area.

8.5 Recommendations for further research

With the use of the grounded theory methodology the substantive theory of *finding meaning* to overcome *hiding behind a mask* revealed the complexity of issues and diversity of experiences shared by perioperative nurses when participating in multi-organ procurement surgical procedures. As revealed by the study participants several influencing conditions were identified which had a bearing on the participant's experiences of the basic social psychological problem of *hiding behind a mask* and the basic social psychological process of *finding meaning*.

This study is the first conducted within an Australian context on perioperative nurses and adds a new knowledge base to aspects and issues identified within the international literature on perioperative nurses' experiences when participating in procurement surgical procedures. There are several areas which need further in-depth exploration and development as a result of the research findings identified within this thesis. Although this study highlights several important aspects impacting on the perioperative nursing profession, the identified substantive theory needs to be tested and expanded empirically within the broader health care environment within Australia to further confirm these findings. Such further research could also use the developed substantive theory to compare and test relationships amongst variables and concepts already identified to be measured and operationalised as an empirical model.

Further research which explores the perioperative nurses experiences in other state settings with the use of other qualitative and quantitative methodologies would address many of the limitations of the study results and sample. In addition, further research needs to be conducted on exploring the educational needs of health staff closely involved in these surgical procedures. Further education needs to be conducted on the emotional well-being and effect of stress on health professionals related to procurement surgical procedures. There is also a need to investigate the long term stress and impact on perioperative nurses as a result of participating in procurement surgical procedures. A longitudinal study on the long term effects of perioperative nurses involved in caring for deceased organ donors and DCD donors could be warranted to determine how perioperative nurses continue to cope with multiple organ procurement surgical procedures. Many of the suggested interventions listed in this chapter could be the basis for interventional studies aimed at improving the process and outcome of procurement surgery for perioperative nurses. It would also be worth assessing ultimately if this improvement can be related to better transplantation outcomes across the board.

8.6 Concluding statement

In conclusion, through the use of grounded theory methodology data collected has been used to identify the substantive theory of *finding meaning* to overcome *hiding behind a mask*. This study has served to increase awareness of some of the complex issues perioperative nurses regularly faced when participating in procurement surgical procedures within an Australian context via the objectives of this study which were to: 1) explore and describe the experience, psychological, social processes, interactions and how these impact

on nurses participating in multi organ procurement surgical teams, 2) identify factors that facilitate or inhibit the experience of nurses' involvement in multi-organ procurement, 3) ascertain the interrelationships between the nurse and procurement surgical teams and to 4) generate a substantive theory which fully documents the experience and places it within the context of relevant theoretical literature.

The results of this study are a product of the willingness of the study participants to openly talk about their experiences when participating in procurement surgical procedures and caring for organ donors. It is through their voices that a deeper understanding of their experiences has been gained which aids to increase awareness of the significant contributions perioperative nurses make to procurement surgical procedures. In addition, this knowledge can transform better resources and practices to ensure that these health professionals no longer have to be *hiding behind a mask* when confronted with procurement surgical procedures. It was a privilege to hear and share the stories of perioperative nurses' experiences in these surgical procedures and to emphasis the needs of this specialty group. It is hoped that through these research findings, relevant initiatives and strategies will be implemented to improve perioperative nurses' working roles when participating in multi-organ procurement surgery so as they will continue to be *finding meaning* as a result of their participation in these surgical procedures. It is further anticipated that through this work various stakeholders such as governments, health professionals, and professional organisations will have a greater understanding of the needs of perioperative nurses within this expanding area of health care. Recognition of the needs of the perioperative nursing specialty will ensure that organ procurement and transplantation procedures continue to be undertaken successfully at a high standard for donor patients, recipients and health care professionals within an Australian context. As a starting point, these research findings have the potential to influence changes to the perioperative nursing profession in the areas of clinical initiatives, education, professional support and health policy.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

APPENDIX A

memorandum

To	Associate Professor Dianne Wynaden, Nursing & Midwifery
From	A/Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval HR 152/2008
Date	15 December 2008
Copy	Zaneta Smith Graduate Studies Officer, Faculty of Nursing & Midwifery



Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Committee (HREC) for the project titled "Nurses Participating In Multi-Organ Procurement Surgical Teams: A Grounded Theory Study". Your application has been reviewed by the HREC and is **approved**.

- You are authorised to commence your research as stated in your proposal.
- The approval number for your project is **HR 152/2008**. Please quote this number in any future correspondence.
- Approval of this project is for a period of twelve months **17-11-2008 to 17-11-2009**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **17-11-2009**.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Divisional Graduate Studies Committee.
- The following standard statement **must be** included in the information sheet to participants:
This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 152/2008). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development:

When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Regards,

A/Professor Stephan Millett
Chair
Human Research Ethics Committee

APPENDIX B



Department of Health
Government of Western Australia
South Metropolitan Area Health Service

Royal Perth Hospital



ETHICS COMMITTEE

Prof F M van Bockxmeer PhD MHGSA, ARPCA, FAHA
PathWest Laboratory Medicine
Tel: 9224 2322 Fax: 9224 2491
Email Frank.VB@health.wa.gov.au

Room 4112 Level 4, Kirkman House
Tel: 9224 2292

Ref: EC 2009/029

(This number must be quoted on all correspondence)

6th April 2009

Prof Gavin Leslie
Critical Care Division
Royal Perth Hospital

Dear Gavin

**EC 2009/029 Nurses participating in multi-organ procurement surgical teams:
A grounded theory study**

Thank you for submitting the above project for approval by the RPH Ethics Committee.

Under the revised National Statement (NS) (March 2007) it would appear that this project meets the conditions set out in paragraphs 5.1.22 and 5.1.23 and 2.1.7 for low to negligible risk research and has been reviewed by the Ethics Committee's low risk sub-committee.

I am pleased to advise that the sub-committee has **approved** your study.

The Committee is obliged by the provisions of the revised "National Statement" of the NH&MRC (2007) to monitor progress of all studies until completion. Therefore, this approval is granted on the understanding that you will advise of any protocol amendments and submit an annual report to the Committee.


Yours sincerely

Prof Frank van Bockxmeer
Chairman, Royal Perth Hospital Ethics Committee


The Royal Perth Hospital Ethics Committee is constituted and operates in accordance with NHC & MRC Guidelines.

Copy: Zaneta Smith, PhD candidate, School of Nursing and Midwifery, Curtin University

APPENDIX C



Fremantle Hospital and Health Service
Kaleeya Hospital Campus
Rottnest Island Nursing Post



Zaneta Smith
PO Box Z5573
London COURT
Perth 6831

26th May 2009

Dear Zaneta,

Re: Proposal: Nurses participating in multi-organ procurement surgical teams: A grounded theory approach"

I have perused the documentation that you have provided and I do not consider that the study raises any specific ethical issues for Fremantle Hospital. I am pleased to advise that, on the basis nursing staff are happy to be involved; your study is approved by the South Metropolitan Area Health Service Nursing Research Review Committee (SMAHS NRRC) under the reciprocal nursing agreement between Royal Perth Hospital and Fremantle Hospital.

Under the reciprocal agreement, approval of proposal amendments and reporting of adverse events is the responsibility of the primary committee, in this instance Royal Perth Hospital Ethics Committee. However, the SMAHS NRRC would like to be informed of any changes to the proposal and any unexpected events should they arise.

Please note it is the responsibility of the investigator to notify the Committee of any variation from the original proposal. Should the research be discontinued you are also required to inform the Committee, giving reasons for termination.


Approval is subject to the following requirements:

- A copy of your poster advertising the study for Fremantle Hospital nursing staff is provided;
- A copy of the study's final report is provided to the SMAHS NRRC on completion of the study, and, if the research is not completed within 12 months you are asked to submit a brief progress report;
- The hospital is not identified in any report or publication unless prior permission has been granted.

A progress report is due May 2010.

If you wish to discuss this further please do not hesitate to contact me further on 9431 2129.

Yours sincerely



Sunita McGowan, Adjunct Associate Professor Curtin University
Director Nursing Research & Evaluation
Fremantle Hospital

Healthy Workforce • Healthy Hospitals • Healthy Partnerships • Healthy Communities • Healthy Resources • Healthy Leadership

APPENDIX D



Government of Western Australia
Department of Health
Ethics Ref: 2009-082
Ext 2999



Sir Charles
Gairdner Hospital

9 July 2009

Ms Zaneta Smith
Operating Suite
Sir Charles Gairdner Hospital
Hospital Ave
NEDLANDS WA 6009

Dear Ms Smith

APPLICATION TO CONDUCT HUMAN RESEARCH AT SCGH:

TRIAL No: 2009-082

TRIAL TITLE: Nurses participating in multi-organ procurement surgical teams: A grounded theory study

On behalf of the Sir Charles Gairdner Group Executive I give approval to conduct your research project at SCGH based on the favourable reviews provided to me by the Research Governance Unit and the Sir Charles Gairdner Group Human Research Ethics Committee. This approval is granted until 31 July 2012, and on the basis of compliance with all requirements laid out in your application and with the provision of reports as required by the RGU and approving HREC in giving their favourable opinion (attached).

The responsibility for the conduct of this study remains with you as the Principal Investigator. You must notify the Research Governance Unit of any relevant issues arising during the conduct of the study that may affect continued favourable opinions by the hospital or by an HREC.

Please quote Study number 2009-082 on all correspondence associated with this study.

Yours sincerely

SUE DAVIS
Acting Executive Director of Nursing Services
Sir Charles Gairdner Group
North Metropolitan Health Service

Hospital Avenue, Nedlands, Western Australia 6009
Telephone + 618 9346 3333 Facsimile + 618 9346 3759 T.T.Y. Line + 618 9346 3900
Website: <http://www.scgh.health.wa.gov.au>, ABN: 13 993 250 709

APPENDIX E



OPERATING SUITE -NURSE MANAGERS LETTER OF INTRODUCTION

Dear Manager,

RESEARCH STUDY WITHIN THE OPERATING SUITE

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

My name is Zaneta Smith. I am a Registered Nurse who is investigating the experiences of operating suite nurses involved in the phenomenon of multi organ procurement surgery within teaching hospitals across WA and NSW. This study is part of the requirement for the award of Doctor of Philosophy through the School of Nursing and Midwifery at Curtin University of Technology. The purpose of this study is to explore the nurses' experiences of participating in multi organ procurement surgical teams with the aim of increasing knowledge and understanding of how nurses and surgical teams are affected by involvement in these procedures. The knowledge gained will be of major significance to operating suite nurses, surgical teams, and to procurement and hospital organisations to establish the nature of nursing work in this specialised area of health care and make necessary recommendations as appropriate.

I have enclosed for your perusal copies of my proposal, an information sheet and a consent form. This research has been approved by the Curtin University of Technology Human Research Ethics Committee and the various participating hospitals; Royal Perth Hospital Human Research Ethics Committee, Fremantle Hospital Research Ethics Committee and Sir Charles Gairdner Human Research Ethics Committee. For further information, or clarification concerning this research you are free to contact me on my mobile number 0417 489 098; or by Email: zaneta.smith@bigpond.com.au or zaneta.smith@postgrad.curtin.edu.au. If you prefer, you may contact my supervisors, Associate Professor Dianne Wynaden on (08)9266 2203 or Email: d.wynaden@curtin.edu.au and Associate Professor Gavin Leslie on (08) 9266 2070 or Email: G.Leslie@curtin.edu.au.

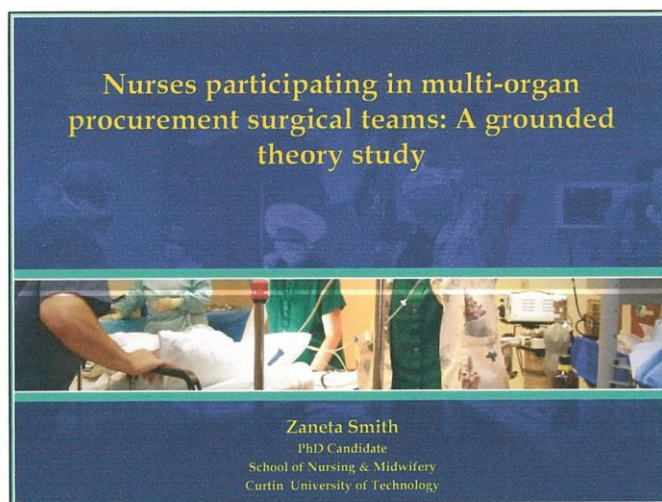
Ethics approval for this study has been obtained from Curtin University of Technology (Reference Number: **HR 152/2008**) and the **RPH Ethics Committee (EC # 2009/029)**.

I sincerely appreciate your consideration to participate in this study and your support towards this research.

Thanking you in anticipation

Zaneta Smith
PhD Candidate
School of Nursing and Midwifery
Curtin University of Technology

APPENDIX F



APPENDIX G

RESEARCH STUDY

School of Nursing & Midwifery

Curtin
University of Technology



Nurses participating in multi-organ procurement surgical teams: A grounded theory study.

INVITATION TO WA OPERATING SUITE NURSES

Investigators:

Zaneta Smith,
PhD Candidate,
Curtin University of Technology

Prof Gavin Leslie,
Royal Perth Hospital
Curtin University of Technology

**Assoc Prof Dianne
Wynaden,**
Curtin University of Technology

You are invited to participate in a research study on your experiences as part of a surgical team member involved in multi-organ procurement surgery. Participation in this study will entail a 60 minute interview at a place and time convenient to you.

**For further information contact
Zaneta Smith
0417 489 098**

This study has been approved by Curtin University Ethics Committee
HR 152/2008

APPENDIX H



INFORMATION SHEET

Researcher: Zaneta Smith

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

Dear Colleague,

This information sheet outlines the purpose of the study and provides a description of your involvement and rights as a participant should you decide to participate in this study. Please take time to read the following information carefully and do not hesitate to clarify anything which is not clear.

My name is Zaneta Smith. I am a Registered Nurse who is investigating the experiences of operating suite nurses involved in the phenomenon of multi organ procurement surgery within teaching hospitals across WA and NSW. This study is part of the requirement for the award of Doctor of Philosophy through the School of Nursing and Midwifery at Curtin University of Technology. The purpose of this study is to explore the nurses' experiences of participating in multi organ procurement surgical teams with the aim of increasing knowledge and understanding of how nurses and surgical teams are affected by involvement in these procedures. The knowledge gained will be of major significance to operating suite nurses, surgical teams, and to procurement and hospital organisations to establish the nature of nursing work in this specialised area of health care and make necessary recommendations as appropriate.

VOLUNTARY PARTICIPATION

You are being asked to participate in this research study because you are an operating suite nurse who has had experience participating in multi-organ procurement procedures. Your participation in this research is voluntary; you have the right to withdraw at any point and without any prejudice. In the event that you do withdraw from this study, all the information you have already provided will be kept in a confidential manner.

PARTICIPATION IN THIS STUDY

Participation in this study will involve an interview of approximately 60 minutes at a time and place convenient to you. The interview will be audio taped and will focus on issues such as your thoughts, feelings, actions and experiences of participating in multi organ procurement surgery. A follow up interview of 30 minutes may be required to clarify any issues raised in the first interview. These audiotapes will be transcribed and the transcripts de-identified. Prior to each interview, there will be an opportunity to ask questions and confirm your continued participation in this study.

CONFIDENTIALITY

Any information that is obtained in connection with this study will be kept private and confidential. The results of this research study will be presented in a thesis, meetings and publication; however, descriptions of your identity and location will not be disclosed. All interview forms, audiotapes and transcriptions from the interviews will contain a pseudonym and this information will be locked away. These records will be kept for a period of 5 years and will be destroyed thereafter.

BENEFIT OF PARTICIPATION IN STUDY

You may gain no direct benefit from the study. However, you may find participation in this study validating. The findings have the potential to be utilised to further support the health professionals involved in this important work.

FURTHER INFORMATION

This research has been reviewed by the Curtin University of Technology Human Research Ethics Committee. For further information, or clarification concerning this research you are free to contact me on my mobile number 0417 489 098; or by Email: zaneta.smith@bigpond.com.au or zaneta.smith@postgrad.curtin.edu.au.

If you prefer, you may contact my supervisors, Associate Professor Dianne Wynaden on (08)9266 2203 or Email: d.wynaden@curtin.edu.au and Associate Professor Gavin Leslie on (08) 9266 2070 or Email: G.Leslie@curtin.edu.au. Ethics approval for this study has been obtained from Curtin University of Technology Reference Number: **HR 152/2008**.

I sincerely appreciate your consideration to participate in this study and your support towards this research.

Thanking you in anticipation

Zaneta Smith
PhD Candidate
School of Nursing and Midwifery
Curtin University of Technology

APPENDIX I

School of Nursing & Midwifery



CONSENT FORM (INTERVIEW)

Researcher: Zaneta Smith

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

I _____ have read the Health Professional Interview Information Sheet and have been encouraged to ask questions. I have received answers to questions to my satisfaction. I have received a copy of the Health Professional Information Sheet (Interview) for my records and future reference.

I understand the nature and intent of the study and have had the opportunity to ask questions. I understand that the interview will last approximately 60 minutes and will be audio taped. I may decline to answer any questions and ask for the tape recorder to be turned off during the interview. I may cease the interview at any time without any prejudice. I understand that all information provided is kept confidential. I agree that research gathered for this study may be published provided no names or any other information that may identify me is not used. I understand that my participation is voluntary and that I may withdraw my consent and terminate my participation at any time without incurring penalty.

I have read this consent form and I agree to participate in the study "Nurses participating in multi-organ procurement surgical teams: A grounded theory study" and give my consent freely.

I agree to the terms:

Interview Participant Name _____

Interview Participant Signature _____ Date _____

I agree to the terms:

Researcher Name _____

Researcher Signature _____ Date _____

APPENDIX J

Flyer advertised in ACORN Journal (2009), 22 (4), p. 41.

RESEARCH STUDY

School of Nursing & Midwifery | **Curtin**
University of Technology



Nurses participating in multi-organ procurement surgical teams: A grounded theory study.

INVITATION TO NSW OPERATING SUITE NURSES

Investigators:

Zaneta Smith,
PhD Candidate,
Curtin University of Technology

Prof Gavin Leslie,
Royal Perth Hospital
Curtin University of Technology

**Assoc Prof Dianne
Wynaden,**
Curtin University of Technology

Have you assisted in a multi-organ procurement case?
You are invited to participate in a research study on your experiences as part of a surgical team member involved in multi-organ procurement surgery.

Participation in this study will entail a 60 minute interview at a place and time convenient to you.

For further information contact
Zaneta Smith
0417 489 098
E-mail: zaneta.smith@bigpond.com.au

This study has been approved by Curtin University Ethics Committee
Reference No: HR 152/2008

APPENDIX K

Flyer advertised in ACORN Journal (2010), 23 (1), p. 57.

**PHD
RESEARCH
STUDY**

School of Nursing & Midwifery | **Curtin**
University of Technology



**Nurses participating in multi-organ procurement
surgical teams: A grounded theory study.**

INVITATION TO NSW OPERATING SUITE NURSES

Investigators:

Zaneta Smith,
SDN-Perioperative Course
Sir Charles Gairdner Hospital
PhD Candidate,
Curtin University of Technology

Prof Gavin Leslie,
Royal Perth Hospital
Curtin University of Technology

**Assoc Prof Dianne
Wynaden,**
Curtin University of Technology

FURTHER NURSES REQUIRED

Have you assisted in a multi-organ procurement case?
You are invited to participate in a research study on your experiences as part of a surgical team member involved in multi-organ procurement surgery.

Participation in this study will entail
a 60 minute interview at a place
and time convenient to you.

For further information contact
Zaneta Smith
0417 489 098
E-mail: zaneta.smith@bigpond.com.au


This study has been approved by Curtin University Ethics Committee
Reference No: HR 152/2008

APPENDIX L

Flyer advertised in the NSW OTA newsletter "Suite Talk" December 2009 edition.

**RESEARCH
STUDY**

School of Nursing & Midwifery | **Curtin**
University of Technology



**Nurses participating in multi-organ procurement
surgical teams: A grounded theory study.**

INVITATION TO NSW OPERATING SUITE NURSES

Investigators:

Zaneta Smith,
PhD Candidate,
Curtin University of Technology

Prof Gavin Leslie,
Royal Perth Hospital
Curtin University of Technology

**Assoc Prof Dianne
Wynaden,**
Curtin University of Technology

Have you assisted in a multi-organ procurement case?
You are invited to participate in a research study on your
experiences as part of a surgical team member involved
in multi-organ procurement surgery.
Participation in this study will entail
a 60 minute interview at a place
and time convenient to you.

For further information contact
Zaneta Smith
0417 489 098
E-mail: zaneta.smith@bigpond.com.au

This study has been approved by Curtin University Ethics Committee
Reference No: **HR 152/2008**

APPENDIX M



Nurses participating in multi-organ procurement surgical teams: A grounded theory study

**Researcher: Zaneta Smith
PhD Candidate Curtin University of Technology
Associate Professor Dianne Wynaden and Professor Gavin Leslie**

January, 2010

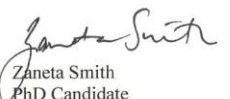
Dear NSW Colleague,

Thank you for expressing an interest in participating in the PhD research study investigating the experiences of operating suite nurses involved in the phenomenon of multi-organ procurement surgery within teaching hospitals across WA and NSW.

Please find enclosed further information in regards to my study. I will be planning a visit to Sydney after the New Year in which to undertake interviews which I will finalise once I have an indication of willing participants. I am also willing to undertake 60 min interviews here in Perth if any nurses are attending the National ACORN Conference in May. **If you could please contact me to express your interest and provide an indication of interview availability and venue NSW/WA preference would be most helpful.** Please feel free to get in touch with me via e-mail or my mobile as I am happy to discuss any further queries you may have in relation to my study.

I sincerely appreciate your consideration to participate in this study and your support towards this research.

Thanking you in anticipation


Zaneta Smith
PhD Candidate
School of Nursing and Midwifery
Curtin University of Technology

APPENDIX N

School of Nursing & Midwifery



DEMOGRAPHIC PROFILE QUESTIONNAIRE

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

Please complete the following questionnaire form by ticking the answer that most accurately describes your background/situation and enter details on the space as requested.

1. GENDER

Male ☐
 Female ☐
2. AGE _____
3. COUNTRY OF BIRTH _____
4. RELIGION _____
5. EMPLOYMENT

NSW ☐
 WA ☐

Clinical Position
 Present area of Work
 Years of Professional Service
 Length of Current Employment

Work Status

Fulltime ☐
 Part-time ☐
 Casual ☐
 Shift Worker ☐
6. EDUCATION

Highest Qualification Achieved
 Hospital Trained/ Hospital &Country
 University Trained/University & Country

7. EXPERIENCE IN PROCUREMENT

Number of times involved in procurement procedure
 Participation Role (Scrub/Scout/Anaesthetic Nurse/Other)
 Previous Experience (Where gained)
 Previous Training Provided or Undertaken
 Was Counselling provided Post Procedure

Researcher's Use Only

Interview Code Number _____
 Hospital Code Number _____
 Date Completed _____

APPENDIX O



SEMI STRUCTURED INTERVIEW GUIDE

Researcher: Zaneta Smith

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

The semi-structured interview format will be used in this study. The researcher will meet with the participant approximately 15 minutes before the interview begins. During this time the researcher will establish rapport with the participant and explain the purpose of the study. The researcher will inform the participant that they will receive a report on the outcomes of the study and that the researcher would be willing to conduct a presentation to any group on the outcomes of the study.

The interview will commence by asking the participant the following question:

How long have you worked in the operating room?
Where have you worked?
Have you worked overseas?
What specialties?

The following prompts will be reflected in subsequent questions used in the interview to ensure that the objectives of the study are met.

Can you tell me about your experiences participating in multi organ procurements surgery?
What has that experience been like for you?

Themes

Tell me about your experiences of participating in organ procurement?
What was the role you played within the team?
What were the major issues for you in relation to participation?
How would you describe the experience from a personal and professional perspective?
What was your experience with your surgical team members?
What things helped you in your role?
What factors hinder your role?
What difficulties did you have to manage?
Would you advocate organ donation?
Do you believe your religion or faith impacts upon your participation experience?

APPENDIX P



PARTICIPATION THANKYOU LETTER

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

March, 2010

Dear _____,

I would like to thank you again for giving freely of your valuable time in participating in the above research study by sharing your experiences working in multi-organ procurement surgery via an interview.

Your contribution towards this study is appreciated. If you have any additional comments, please do not hesitate to contact me on the number below.

Kind Regards

Zaneta Smith RN
PhD Candidate
School of Nursing and Midwifery
Curtin University of Technology
M 0417 489 098
E-mail: zaneta.smith@bigpond.com.au

APPENDIX Q



CONFIDENTIALITY AGREEMENT FOR INTERVIEW TRANSCRIBER

Nurses participating in multi-organ procurement surgical teams: A grounded theory study

I _____ will be assisting the Researcher Zaneta SMITH PhD Candidate from the School of Nursing at Curtin University undertaking the study “Nurses participating in multi-organ procurement surgical teams: A grounded theory study” by transcribing data from taped interviews. All interviews for transcription will be provided to me (the transcriber) in a numerical code format to ensure anonymity of participants. As the interview transcriber any information that is obtained in connection with this study; audiotapes and transcriptions from the interviews will be kept private and confidential. All audiotapes and transcriptions will be returned to the Researcher once transcription has been complete.

I undertake to comply with the above confidentiality conditions as required by the researcher as a student of Curtin University of Technology and as stated above to protect the research participants of the above study’s confidentiality.

I agree to the terms:

Interview Transcriber Name _____

Interview Transcriber Signature _____ Date _____

I agree to the terms:

Researcher Name _____

Researcher Signature _____ Date _____